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ABSTRACT

Intended for use in inservice teacher and professional education, as well as with secondary level students, the curriculum guide is designed as part of Project Protection to promote understanding of the individual and societal problems of child maltreatment in terms of prevention. The document contains six units which deal with the following aspects of child abuse and neglect: reasons for past and present maltreatment in the society; acts of physical and psychological neglect and abuse, physical and psychological manifestations of maltreatment, and child maltreatment as compared to acceptable child-rearing practices; the typically abusive or neglectful caretaker, characteristics of the vulnerable child, and ability to cope with stress as the key factor in the episode of child maltreatment; the psychodynamic dimension of child maltreatment in relation to both the child's and caretaker's conscious and unconscious reactions to stress; dysfunctions within society, the family, and the individual which could result in circumstantial, incidental, or intentional child maltreatment; and the variety of help available to both the caretaker and the maltreated child. It is noted that units may be taught separately in 5 to 10 days according to the needs and interests of students, or that all six units may be taught sequentially as a complete course of study. Each unit includes appropriate literature and supplementary instructional materials. The Montgomery County (Maryland) school system's current policy statement and reporting procedures for child abuse and neglect are also provided, as well as an annotated bibliography of selected literature for use at the professional level. (Author/SBH)

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Montgomery County Public Schools
Department of Supplementary Education and Services
Rockville, Maryland

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UNDERSTANDING CHILD MALTREATMENT:

HELP AND HOPE

A Course of Study

(Pilot Edition)

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TABLE OF CONTENTS

Page

ACKNOWLEDGMENTS v

INTRODUCTION ix

OVERVIEW xi

STUDENT OUTCOMES xiii

EVALUATION xxi

INSTRUCTIONAL PLANS xxii

CLASSROOM REFERRALS: THE ROLE OF THE TEACHER xxv

OUTLINE OF CURRICULUM CONTENT xxxiii

UNIT I. The Phenomenon of Child Maltreatment 1

UNIT II. The Nature of Child Maltreatment 67

UNIT III. The Episode of Child Maltreatment 109

UNIT IV. The Psychodynamics of Child Maltreatment 169

UNIT V. The Problem of Child Maltreatment 233

UNIT VI. Child Maltreatment: Help and Hope 343

ANNOTATED BIBLIOGRAPHY 457

APPENDICES

A. Instructional and Performance Objectives by Unit

B. Classroom Instructional Materials by Unit

C. Definition of Terms by Unit

D. Classroom Learning Center for Child Maltreatment

E. Speakers and Information Resources

F. Sexual Molestation of Children

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INTRODUCTION

Over the past decade, there has been increasing awareness that child maltreatment constitutes a major threat to the mental and physical well being of children in our society and thus to its future generations. In response to this growing concern, the federal government, through the auspices of the Department of Health, Education and Welfare, has supported efforts toward solution of the problem.

In July 1974, Montgomery County Public Schools became, through Project PROTECTION, one of three school systems in the nation to receive a Title III grant from the U. S. Office of Education for the purpose of exploring multidisciplinary approaches to the problem of child maltreatment. One of these approaches has been through curriculum development in the hope that through the educational process in the public schools of our nation, the vicious cycle of child maltreatment can be broken in our society.

With Diane D. Broadhurst as project director, a pioneer effort has been made to develop a course of study concerned with the prevention of child maltreatment. This basic curriculum seeks to promote understanding of both the individual and societal problem of child maltreatment. Understanding Child Maltreatment: Help and Hope is a result of this effort. The literature research, curriculum design, and text for the course of study are the work of Maxwell C. Howard, Curriculum Specialist/Writer, Montgomery County Public Schools.

The instructional guide has been designed for maximum flexibility. It may be utilized in the following ways:

- As the instrument for training teachers and professional staff in understanding and prevention of child maltreatment

- As the instrument for incorporating units on the understanding and the prevention of child maltreatment, within appropriate subject areas at the secondary school level

- As the instrument to be utilized in designing classroom activities and assessment measures appropriate for a range of student learning levels

For all teachers and professional staff, in-service training in understanding and prevention of child maltreatment is highly recommended. For those teachers at the secondary level who plan to teach units based on the instructional guide, special in-service training is recommended as prerequisite.

Dr. Jerry M. Weiner, a noted psychiatrist, has said "A happy innocent childhood is one of the enduring myths of our culture. Its perpetuation may depend upon our collective inclination as a society to banish from our concern the unsightly ulcer of unhappy, disturbed or deprived children." Through the optimal utilization of this course of study, Montgomery County Public Schools will assume a leadership position and become a model for other school systems throughout the nation in prevention of child maltreatment through the educational process.

OVERVIEW

Understanding Child Maltreatment: Help and Hope has been developed in direct response to the recommendation of the Board of Education of Montgomery County which states that

> ....the school program should be based on the study of broad human concerns, flexible enough to deal with changing concerns and at the same time related to the needs, interests, and concerns of each student. The program should offer opportunities for decision-making. It should help the student develop the capacity to learn throughout his lifetime, to respond to and understand other human beings, and to accept full responsibility for the results of his actions.*

The course of study consists of six instructional units, each concerned with a different aspect of child maltreatment.

UNIT I. THE PHENOMENON OF CHILD MALTREATMENT is concerned with child maltreatment in its broadest sense, as a societal phenomenon. It addresses the question of -- What is it? Reasons for child maltreatment as a historical phenomenon are explored. Students are made aware of the forms of child maltreatment in the past. They are also introduced to child maltreatment as a contemporary phenomenon, together with the medical, statistical, and sociological evidence of child maltreatment in society today. Reasons for the present-day phenomenon of child maltreatment are discussed.

UNIT II. THE NATURE OF CHILD MALTREATMENT addresses the question of -- What is it like? The goal here is recognition. The spectrum of child maltreatment is identified as acts of physical and psychological abuse and/or neglect by a caretaker. The caretaker is broadly identified. Acts of physical and psychological abuse and acts of physical and psychological neglect are described. Acts of psychological abuse and neglect (without physical abuse or neglect) are also discussed, along with the physical and psychological manifestations of maltreatment in the child. Child maltreatment is compared and contrasted with acceptable or usual child-rearing practices in society today.

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* Goals of Education of Montgomery County, February 12, 1973.

UNIT III. THE EPISODE OF CHILD MALTREATMENT responds to the question of -- Who does it? Who and what are involved when this tragic drama occurs? The typically abusive or neglectful caretaker is described. Characteristics of the vulnerable child are discussed. The role of the passive partner and the effects of witnessing the maltreatment episode on the sibling on-looker(s) are also explored. Students are introduced to the various aspects of stress -- the "triggering" mechanism -- and ability to cope with stress as a key factor in the episode of child maltreatment.

UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT endeavors to answer the haunting question -- Why do they do it? Students develop insight into the complex psychodynamic interaction which takes place among the components in a single act of child maltreatment. The psychodynamic dimension of child maltreatment is explored in relation to the caretaker's conscious and unconscious reactions to the child and the child's reactions to the caretaker. The psychodynamic dimension of child maltreatment is further explored in relation to both the child's and the caretaker's conscious and unconscious reactions to stress. The vicious cycle of child maltreatment as it occurs and recurs from one generation to the next within a given family is described.

UNIT V. THE PROBLEM OF CHILD MALTREATMENT seeks to define the complex individual and societal problem of child maltreatment. Students explore those dysfunctions within society, the family, and the individual which could result in circumstantial, incidental, or intentional child maltreatment. Students predict circumstantial, incidental, or intentional child maltreatment in relation to individual ability to cope with stress. Child maltreatment, whether circumstantial, incidental, or intentional, is defined according to federal, state, and local child abuse and neglect laws. The history and present-day status of child maltreatment law is reviewed, and the local reporting process is examined in detail.

Finally, UNIT VI. CHILD MALTREATMENT: HELP AND HOPE responds to the double-pronged question of what can be done to help when the individual problem of child maltreatment occurs and where hope lies in the prevention of the societal problem of child maltreatment. Students are introduced to the variety of help available to both the caretaker and the maltreated child. Those who must respond and the kinds of responses that must be made for the prevention of the societal problem of child maltreatment are identified.

STUDENT OUTCOMES

Among the goals adopted by the Board of Education for students enrolled in Montgomery County Schools is one which speaks to the individual and society:

> * Every person must learn to live in a society. The school must help each student develop an understanding of man and of how the individual depends upon others and they on him. This requires that each student gain
>
> - knowledge of himself and the characteristics, needs, and desires he shares with others
> - sensitivity to others and their ideas, and the ability to act responsibily in various situations
> - the ability to function productively as a member of a group
> - familiarity with the legal, moral, ethical, and cultural heritages of his and other societies
> - knowledge of the various political systems and philosophies of the world

Through the instructional objectives for Understanding Child Maltreatment: Help and Hope, students will be assisted in their efforts to attain the above outcomes.

The instructional objectives for each unit are as follows:

The student will be able to:

- compare the historical and contemporary phenomenon of child maltreatment in society (Unit I)
- distinguish the nature of child maltreatment from acceptable or usual child-rearing practices today (Unit II)
- describe the components in an episode of child maltreatment (Unit III)
- explain the psychodynamic dimension of child maltreatment (Unit IV)

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* Goals of Education of Montgomery County, February 12, 1973

- identify the individual and societal problem of child maltreatment (Unit V)

- state the provisions of federal, state, and local child maltreatment law (Unit V)

- recommend responses to the problem of child maltreatment which provide help for both the maltreated child and the caretaker (Unit VI)

- recommend responses which provide hope for prevention of child maltreatment in society (Unit VI)

In achieving the instructional goals of Understanding Child Maltreatment: Help and Hope, students will be assisted in their efforts to attain the students outcomes of specific courses in the Montgomery County Public Schools Program of Studies.

Social Studies

Problems of the Twentieth Century - Grade 12

By the end of the course, the student will be able to:

- explain the rights and responsibilities of the individual in a democratic framework

- identify patterns of behavior basic to the socialization process, and relate them to genetic and environmental factors

- list characteristics of kinship and evaluate the role of the family in contemporary society

- identify characteristics of disruptive group behavior, and illustrate the effect it has on social progress

- examine and analyze legislation related to modifying social behavior

Cultural Anthropology - Grade 12

By the end of the course, the student will be able to:

- identify terms and concepts necessary to explain basic cultural kinship practices and relate their importance to family, extended family, tribe, and society

- identify and determine behavioral elements of a culture through the art, music, or folklore of that culture

Psychology - Grades 11, 12

The instructional objectives, generalizations, and sample content of Understanding Child Maltreatment: Help and Hope are directly related to the "Substantive Generalizations for Psychology" developed for the High School Psychology Elective.*

- Individual functioning may be described as developed patterns derived from interrelated biological and cultural factors.
- The conflict between the forces for change and those for stability is present in every individual but occurs with varying intensity at different times and within altered contexts.
- The individual's basic needs are reflected in his aspirations and his utilization of resources.
- The antecedents and consequences of specific behaviors are complex and interwoven.
- The behaviors of the individual are not capricious; the patterns which they follow are subject to prediction.
- The increasing interdependence of the society and the individual makes increasing demands upon his development and his contributions.

Sociology I - Grade 12

By the end of the course, the student will be able to:

- identify methods of cultural transmission and the impact on the society or individual
- explain what is meant by social control and distinguish between formal, informal, and institutional control
- identify social roles in terms of social organization and structure
- summarize forces that influence social change and identify terminology associated with social change
- identify several social institutions and explain how various examples exercise control; and discuss advantages or disadvantages in terms of each individual student's own value system

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* MCPS Bulletin No. 272, pp. xi, xii

Health and Safety Education

Family Life Education

By the end of the unit, the student will be able to:

- cite the roles and responsibilities of family members
- understand the nature of marriage and its attendant problems of adjustment and fulfillment
- understand the desirability of preparation for marriage and parenthood
- consider the obligations and responsibilities of parents to each other and to their children
- explore the relationship between family size and family life

Home Economics

Home Economics IV - Grade 12

By the end of the course, the student will be able to:

- formulate the major responsibilities for parenthood
- give examples by age level of developmental characteristics of children from birth to age six
- identify principles of prenatal and infant care

Relationships (Marriage and Family) Grades 11, 12

By the end of the course, the student should be able to:

- understand some of the ways in which behavior is affected by the self-concept
- analyze various means of communication between individuals
- analyze how individuals are influenced by perception
- identify emotions, and list some ways of adjusting to them
- evaluate role expectations

- have some insight into causes of conflict between generations
- recognize the various aspects of the family life style
- be aware of the kinds of problems inherent in family living and of techniques used in problem solving

Human Development in the Family

By the end of the course, the student will be able to:

- identify the needs and characteristics of preschool children
- help meet the needs of preschool children
- demonstrate acceptance of the worth of the individual
- demonstrate ability to communicate in a meaningful manner
- be aware of some of the effects of love upon the development of the individual
- understand the stages in the family life cycle
- understand the worth of the family unit
- be aware of the problems and of the techniques of problem-solving confronted by people living in a family unit
- demonstrate the steps in the decision-making process

Child Development Laboratory - Grades 11, 12

By the end of the course, the student will be able to:

- recognize the role of play in a child's learning and personality development
- plan and assist with activities for preschool children
- cite characteristics of children in primary grades
- record behavior and learning skills of children in a clear, concise, objective manner

- construct materials and conduct activities for curriculum appropriate for primary or special education children
- differentiate between the curriculum for preschool and that for primary grade levels
- identify and compare works of some educators and theorists
- recognize professional requirements and responsibilities of teachers, principals, and other staff members in the elementary school
- identify educational institutions, professional organizations, and vocational opportunities which provide for further growth in early childhood education or related fields
- compile learnings developed in meeting the needs of children in a classroom or group setting that prepare one to assume parental responsibilities
- identify and examine self-discoveries recognized as outcomes of the study and experiences in early childhood education
- evaluate self in terms of personal qualities necessary for success as an intern and in relation to career possibilities
- improve competencies in self-development through understanding of early childhood development
- demonstrate skills in working with children that relate to the guidance, behavior, needs, and characteristics of children
- show evidence of some understanding and appreciation of the satisfactions and joys of working with preschool children
- better understand self and others through the use of resource materials and through the observation of children's behavior
- recognize the importance of accurate, objective recordkeeping
- record observations in an objective manner according to prescribed techniques
- recognize some of the personal qualities and skill requirements of child-centered vocations
- improve competencies in self-development through Child Development Laboratory experiences

Training for Preschool Aides - Grades 11, 12

By the end of the course, the student will be able to:

- have some knowledge of the characteristics, needs, and behavior of preschool children
- relate with children as individuals in groups
- select methods and procedures needed to meet the needs of preschool children
- understand the importance of play in the child's learning and personality development
- recognize learning that better prepares one to assume parental responsibilities
- develope attitudes and skills needed to work with children, employees, and fellow employees
- improve competencies in self-development through skills involving the care of preschool children

EVALUATION

In the Policies and Procedures Handbook, the revised MCPS Regulation 355-4, dated October 1, 1975, defines the instructional objective as "a general statement of what the student should attain"; the performance objective as "a specific statement of what the student should be able to do."

For each instructional objective in the course of study, sets of performance objectives have been designed with specific classroom activities and procedures developed for each set. The performance objectives are measurable and may be used as indicators of student attainment of the instructional objectives.

Each unit contains an evaluation section with sample assessment measures for each performance objective in the unit, and criteria for satisfactory attainment of each objective are itemized. For each unit, a class record form has been designed for the teacher to record student attainment of the performance objectives for that unit. For the student, an individual record form has been designed which includes the performance objectives for each of the six units. Sixty percent satisfactory attainment for the total number of performance objectives attempted by the student is suggested as the basis for course credit.

Each performance objective contains a statement of the behavior desired of the learner in demonstrating attainment of the objective. The key word which specifies the behavior is the verb. In order to prevent misunderstanding, both the teacher and the student should have a common understanding of the meaning of the key words. A Key Word List is therefore provided with a description of the behavior the learner should use in demonstrating attainment of the objective.

Teachers should make every effort to clarify the performance objectives for students. The teacher must have a thorough understanding of the intent of each performance objective in relation to the appropriate instructional objective and be able to communicate this intent to the learner. The learner must also know what is expected of him, so that it is essential also for the student to have a clear understanding of the behavior described in each performance objective.

Appendix A lists instructional and performance objectives by unit. Also provided in the appendix is a Key Word List which includes a description of all key words used in the objectives.

INSTRUCTIONAL PLANS

SELECTION OF UNITS

Each unit in the course of study is a self-contained unit which utilizes the remaining units as resource material. The curriculum design permits the teacher to select the particular unit most appropriate to a specific subject area. Individual classes wishing to focus on a particular aspect of child maltreatment may elect to study the unit which deals with that aspect. Teachers should plan a minimum of two weeks (ten class periods) for one unit. Class periods need not be consecutive.

For individual classes wishing to devote additional time to the study of child maltreatment, students may elect any other unit for additional study, according to student interests. In content, however, the material is so structured that Units I and II, Units III and IV, and Units V and VI are more readily taught in sequence. Where students have the option of a nine-week minicourse, the entire course of study may be utilized.

Within the course of study, Unit V represents the core unit. All resource material for Units I through IV is utilized in the teaching of Unit V.

METHOD OF INSTRUCTION

Each unit in the course of study is designed around one or more instructional objectives; and generalizations and sample content have been developed in outline form for each of the instructional objectives. Sets of performance objectives have been developed for each generalization. The performance objectives are based upon the instructional objective and are specific. Within each unit, the performance objectives are sequential. The achievement of each performance objective is based upon the achievement of the preceding objectives.

In carrying out the suggested classroom activities and procedures, the teacher teaches directly toward the objectives. The Suggested Activities and Procedures in the course of study are also sequential and lead only toward the achievement of specific performance objectives. In the sequential steps, there is a gradual unfolding so that each unit, and the six units together, form a learning-teaching experience in which the teacher guides the student toward a deeper and deeper understanding of child maltreatment.

The teacher may use the suggested activities and procedures in the course of study as a checklist. In following the numbered sequence, the teacher should feel free to design and carry out additional instructional activities as necessary, in response to the variety of individual students' interests and needs The development of classroom activities and procedures for a wide range of student learning levels is a part of the piloting process of this curriculum.

INSTRUCTIONAL MATERIAL

The generalizations developed for each unit are utilized throughout the course of study as instructional material. Each is identified by a capital letter and is referred to by unit number; for example, I A, II C, IV B.

The sample content developed for each generalization is also utilized throughout the course of study as instructional material. The sample content is identified according to its position in the outline and is referred to by unit number and generalization; for example, I A Sample Content 1; II C Sample Content 2 b); IV B Sample Content 1 a).

A large amount of additional instructional material has been prepared and assembled for use within each unit. This material is also utilized and referred to throughout the curriculum document. The material is numbered in the order of its use within each unit. It is identified first by the unit Roman numeral; for example, I.6; II.5; VI.16.

The generalizations, sample content, and instructional material form an essential part of the learning-teaching experience and are referred to at specific steps within the sequence of the Suggested Classroom Activities and Procedures. The criteria for satisfactory attainment of the performance objectives are based upon the student's correct utilization of specific instructional material. For purposes of cross-reference, therefore, the numerals provide an important code identification for both students and teachers in the utilization of classroom instructional material.

TERMINOLOGY

The definition of terms forms an important part of the curriculum instruction. In the development of this curriculum, special effort has been made in the selection of terminology.

The effort here has been 1) to select the exact term to communicate the intended meaning; 2) to select only those terms found in a widely used dictionary readily available to students; and 3) to make certain that the definition of the term as found in the dictionary and the meaning of the term as used throughout the document are consistent.

The definitions are quoted (with one exception) from Webster's New Collegiate Dictionary (1974 edition); hence, some may be brief; some may be lengthy. Teachers should use the definitions as points of reference to synthesize the intent and meaning of the terms as used.

CLASSROOM LEARNING CENTER FOR CHILD MALTREATMENT

In lieu of a suitable textbook, a classroom learning center for child maltreatment is suggested to supplement the classroom instruction. A variety of magazines, pamphlets, and article reprints for such a center may be obtained free or at low cost. Because effort, time, and money are involved in assembling the materials, teachers and students should develop a plan for use of the center which would insure availability of the materials for subsequent classes.

AUDIOVISUAL MATERIAL

Overhead transparencies have been prepared to augment the instructional study materials. These transparencies are an essential part of the sequential steps used in the classroom activities and procedures. Since the transparencies for each unit are used also in other units, they are numbered for easier reference, in series throughout the document from 1 to 21.

Appropriate films or videotape presentations are suggested for use within each unit. Students may, however, elect a film from the total list of films included in the curriculum. FILMS AS SUCH MUST NEVER BE USED IN ORDER TO OMIT THE CLASSROOM ACTIVITIES AND PROCEDURES AS OUTLINED IN THE COURSE OF STUDY.

CLASSROOM REFERALS:

THE ROLE OF THE TEACHER

TEACHERS ARE REMINDED

1. Montgomery County Public Schools provides case-finding and family services through its pupil personnel services. A broad range of educational diagnostic services, psychological services, and special placement services are available through the guidance counselor at each school.

2. Montgomery County Services for Maltreated Children and Their Families provides a list of community resources. The list is made available to students through their classroom learning center for child maltreatment. The list is also included in the Instructional Material for Unit VI.

3. The Montgomery County Public Schools' policy on reporting child abuse and child neglect states that "Any Montgomery County Public Schools employee who has reason to believe that a child has been abused or neglected, shall report this information in the form and manner provided." A Policy Statement on Child Abuse and Child Neglect (revised, August 26, 1974) is included in the classroom instructional materials for Unit V.

MONTGOMERY COUNTY SERVICES FOR MALTREATED CHILDREN AND THEIR FAMILIES

Many community resources are available to the individual in Montgomery County. A Directory of Community Resources may be found in libraries throughout the county. For information or help in locating appropriate resources, telephone 279-1900. The following is a general description of services by agency.

DEPARTMENT OF SOCIAL SERVICES

The Protective Service Unit of the Montgomery County Department of Social Services investigates and evaluates all reports of suspected child abuse and neglect to determine the validity of the allegation. Twenty-four hour response to reports of abuse and serious neglect is provided. Continuing services are provided on behalf of abused and/or neglected children who remain in their own homes, in the home of relatives, or in short-term placements through casework and group-work services.

The Maryland Child Abuse Law mandates that reports of suspected abuse be made either to the local department of social services or to the appropriate law-enforcement agency. The agency to which the report is made shall immediately contact the other.

Unique to Montgomery County is the manner in which abuse reports are investigated. In all such reports, the investigation is conducted by a social worker and a Juvenile Aid officer of the police department and is begun within an hour of the oral report. To better implement the immediacy of investigations and to provide evening coverage, a "night shift" worker is maintained physically at the police station from 6:00 P.M. until midnight. The provision for a night duty worker has been in effect since September 1973 and has greatly contributed to a better working relationship between police and social services. The procedure of involving two agencies in the investigation has greatly expedited the immediate investigation of all reports of suspected child abuse.

Reports of suspected neglect are investigated by the Protective Service staff within ten days of the receipt of the report. As with abuse situations, continuing services are provided to the family if neglect is confirmed, or a referral may be made to the Agency appropriate to provide those services needed by the family.

Montgomery County has a number of resources available for families receiving services for neglect and abuse. Within Social Services, the following programs are available to families who meet eligibility requirements:

1. Public Assistance (Aid to Families with Dependent Children, General Public Assistance, and General Public Assistance for Employables)

2. Food Stamps

3. Medical Assistance

4. Emergency Shelter Care Placement -- a local policy and an additional bed subsidy maintain homes to receive children requiring immediate placement 24 hours per day

5. Foster Care -- including the purchase of specialized foster home care, group home care, or institutional care from other agencies.

6. Single Parents Service -- a specialized counseling and planning service for those with unplanned pregnancies

7. Adoption -- including subsidized adoption and permanent foster care

8. Homemaker Service

9. Day Care -- both in family homes and in centers. Montgomery County has 15 non-profit full day centers. Subsidized day care is available in non-profit or proprietary centers.

HEALTH DEPARTMENT

The Health Department provides a special examination procedure for children suspected of being maltreated. This procedure provides that except in cases of serious or life-threatening injuries, any suspected victim of child abuse needing medical examination or treatment, and any child deemed in danger of physical abuse and removed from his home by Protective Service, will be examined by Health Department staff at either the Montgomery Georgetown Comprehensive Clinic in Takoma Park or at the Bethesda Clinic. Whenever a child has sustained serious or life-threatening injuries (or when a case is reported after clinic hours), the child is taken at once to the nearest hospital Emergency Room.

In addition to this special service, the County Health Department has six area centers providing the following:

1. School Health Services -- including nursing service in schools, medical consultation, and vision and hearing screening

2. Preventive health services -- child and adolescent health clinics for medical evaluation, multi-phasic screening, and parent education in child health and development.

3. Health Department Comprehensive Care Clinics (Areas I and IV)

4. Maryland Medical Assistance Program -- sick care provided through the private physician

5. Maternity and Family Planning Services

6. Mental Health Services including purchasing treatment from the Community Psychiatric Clinic. (These services use a sliding scale fee based upon income.)

Among relevant county-wide health services provided centrally are the following:

1. Specialty,consultation services such as those for seizure, cardiac, orthopedic, and multihandicapping problems

2. Passage Crisis Center

3. Juvenile Court Evaluation Team

4. Drug Alternatives Program

5. Day Care Licensing and Consultation Services (health component)

OFFICE OF HUMAN RESOURCES CHILD PROTECTION SERVICES

1. Child Protection Coordinator

The Child Protection Coordinator performs broad functions to ensure unduplicated, adequate services for child protection of and for treatment of abusing/neglectful families; to ensure continuing education for the lay public, educators, health and mental health professionals, the legal community, and para-professionals; to identify gaps and propose measures to fill them; and to suggest and support research and funding for projects involving child abuse and neglect. These educational efforts are aimed both at attempting to prevent abuse and neglect and at increasing the community's ability to recognize and report existing cases.

2. Child Protection Team

The Child Protection Team is a multi-disciplinary group which serves in an advisory and consultative capacity to the Protective Service Unit of the Department of Social Services. The team comprises a Protective Service supervisor; a pediatrician and a public health nurse from the Health Department; a juvenile officer from the Police Department; a pupil personnel supervisor from Montgomery County Public Schools; a lawyer from the County Attorney's office; and a psychiatrist in private practice. The team meets weekly to staff cases of child abuse and neglect and to make recommendations for case handling.

MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS)

MCPS provides case-finding and family services through its pupil personnel services. A broad range of educational diagnostic services, psychological services, and special placements are available.

OTHER COMMUNITY SERVICES

Within the community, Montgomery County has the following services:

1. Public Housing through the Montgomery County Housing Authority
2. Family Services of Montgomery -- a private United Way counseling agency
3. The Community Psychiatric Clinic -- a large private treatment clinic
4. Jewish Social Services -- a multi-functional private social agency partially supported by United Way
5. Catholic Charities -- a multi-functional private social agency
6. Mental Health Association -- an agency offering a number of mental health services including Hotline, a 24-hour-a-day telephone service, operating seven days a week, providing an immediate listening ear and/or referral information for all residents of Montgomery County
7. A number of church-sponsored HELP and FISH groups -- providing emergency food and clothing and information day or night

MONTGOMERY COUNTY PUBLIC SCHOOLS	**Regulation** 525-10
Subject: CHILD ABUSE AND CHILD NEGLECT	**Date of Issue:** October 1, 1974
	Rescision:
Preparing Office: Associate Superintendent for Administration Department of Supplementary Education and Services	

I. PURPOSE

To publish the policy statement of the Board of Education which provides guidelines and procedures for the identification and referral of abused and neglected children

II. POLICY

The Montgomery County Board of Education, recognizing the serious local, state, and national problems of child abuse and child neglect, affirms its position that the Montgomery County Public Schools shall cooperate vigorously to expose these problems by early identification of abuse or neglect and by reporting suspected cases to duly constituted authorities whether or not substantial corroborative evidence is available. School employees are in a unique position to discover potential cases of abuse and/or neglect of children and youth through the age of seventeen years. Employees are required by Maryland law to report suspected cases of child abuse to the Department of Social Services or Juvenile Section of the Montgomery County Police Department. Suspected child neglect is to be reported to the Department of Social Services.

Effective action by school employees can be achieved through recognition and understanding of the problem, knowing the reporting procedures, and participating in the information programs in child abuse provided for Montgomery County Public Schools employees. Guidelines have been developed to provide direction for staff members in reporting suspected child abuse or child neglect cases. Staff personnel should be aware that by statute they are immune from any civil and/or criminal liability when reporting suspected child abuse, and from any civil liability when reporting suspected child neglect. Failure to report, on the other hand, might result in legal action being brought against a staff member and disciplinary action by the school system. Any doubt about reporting a suspected situation should be resolved in favor of the child, and this situation should be reported immediately. Any Montgomery County Public Schools employee who has reason to believe that a child has been abused or neglected, shall report this information in the form and manner provided.

To maintain awareness on the part of all professional staff members, the Montgomery County Public Schools will provide periodic staff development on the subject of child abuse and neglect.

INFORMATION ON AND PROCEDURES FOR REPORTING SUSPECTED ABUSED AND NEGLECTED CHILDREN

A. REPORTING CASES OF CHILD ABUSE

An abused child is any child under the age of eighteen who a) has sustained physical injury as a result of cruel or inhumane treatment or as a result of malicious acts by his parent or any other person responsible for his care or supervision; b) has been sexually molested or exploited, whether or not he has sustained physical injury, by his parent or any other person responsible for his care or supervision.

xxx

MCPS REGULATION 525-10
October 1, 1974

The abuse of children can cause permanent physical damage, and may be fatal. Researchers have found a very significant number of abusing parents were themselves abused as children. Perpetrators of violent crimes against persons – even teenage offenders -- have frequently been found to have a past history of abuse by their parents or guardians.

Once considered a syndrome that affected only children under three, child abuse today is found as frequently among school-age children. Half of the known cases at the present time are school-age children, with the number who are adolescents rapidly increasing. Educators are in a unique position to identify and report child abuse. Every effort must be made to identify abused children and to prevent repeated abuse.

All Montgomery County Public Schools employees are required by law to report suspected cases of child abuse. As soon as an employee has reason to believe that a child may have been abused, he must call the Protective Services Section of the Montgomery County Department of Social Services, 279-1758, or the Juvenile Section of the Montgomery County Police Department, 762-1000. Simultaneously, the reporting person shall notify the principal that a report has been made. The obligation of the principal to report cases of suspected child abuse brought to his attention by his staff is not discretionary, and he shall assure that the case is duly reported if the reporting person has not done so.

When a report of suspected abuse has been made, a police officer accompanied by a social services worker will respond at once.

Within forty-eight hours, the person making the original oral report must send a written report of the incident to the Department of Social Services, with copies to the Montgomery County State's Attorney, the Juvenile Section of the Montgomery County Police Department, and the Supervisor of Pupil Personnel at the central office. Once copy of the report will be kept in a confidential file by the principal but not placed in the pupil's folder. Montgomery County Form 335-44 is to be used for this written report.

1. Immunity

Anyone who reports suspected child abuse in good faith, or who participates in any investigation or judicial proceeding which results from a report of suspected child abuse is immune from civil liability or criminal penalty. Failure to report could result in a lawsuit with the possibility of substantial damages should an injured or murdered child's guardian be able to establish that the school employee had prior knowledge or suspicions which, if reported, might have prevented further injury to the child.

2. Reporting Cases Not Involving Apparent or Obvious Physical Injury

It is not necessary that the reporting employee observe any external physical signs of injury to the child. It is sufficient merely to presume that abuse has occurred when a child complains of having been sexually molested or of pain, which he says has resulted from an inflicted injury. In such cases the report should be made.

Employees should be aware that abused children typically explain injuries by attributing them to accidents in play or to sibling conflict. In any case, no employee should attempt to press a child on the subject of parental or guardian abuse to validate the suspicion of child abuse. Validation of suspected abuse is the responsibility of the Department of Social Services, assisted by the police. Any doubt about reporting a suspected situation is to be resolved in favor of the child and the report made immediately.

3. Purpose of Intervention

Reports of suspected child abuse are carefully investigated jointly by the Police Department's Juvenile Section detectives and social workers from the Department of Social Services. Each case receives a professional evaluation leading to whatever civil action may be necessary to ensure treatment for the family. Treatment may include a full range of therapeutic programs. The abuser is not subject to indiscriminate criminal prosecution. The State's Attorney and the police work closely with all involved professional personnel and authorities to establish alternatives to prosecution, whenever possible.

B. REPORTING CASES OF CHILD NEGLECT

The Montgomery County Department of Social Services has the legal responsibility for evaluating reports of suspected child neglect and for taking legal action to protect a child where necessary. Under Article 77, Section 116A of the **Annotated Code of Maryland**, *any educator who acts upon reasonable grounds in the making of any report required by law, rule, or regulation or who participates in judicial proceedings which result from such report shall be immune from any civil liability which occurs. A neglected child may be one of the following:*

1. *Malnourished; ill-clad; dirty; without proper shelter or sleeping arrangements; lacking appropriate health care*
2. *Unattended; without adequate supervision*
3. *Ill and lacking essential medical care*
4. *Denied normal experiences that produce feelings of being loved, wanted, secure (Emotional neglect)*
5. *Unlawfully kept from attending school*
6. *Exploited; overworked*
7. *Emotionally disturbed due to continuous friction in the home, marital discord, mentally ill parents*
8. *Exposed to unwholesome and demoralizing circumstances*

All suspected child neglect cases should be reported on Montgomery County Form 335-44 to the Department of Social Services and the Supervisor of Pupil Personnel. If there is any doubt or question in reporting such cases, it should be resolved in favor of the child.

C. CONTENT OF REPORTS

Oral and written reports shall contain the following information, or as much data as the person making the report can provide:

1. *The name(s) and home address(es) of the child(ren) and the parent or other person reponsible for the care of the child(ren)*
2. *The present wherabouts of the child(ren) if not at home*
3. *The age(s) of the child(ren)*
4. *The nature and extent of the abuse or neglect suffered by the child(ren), including any evidence or information that may be available to the person making the report concerning previous physical or sexual abuse or neglect.*

(**Board Resolution No. 378-74**, *July 9, 1974, amended by* **Board Resolution No. 452-74**, *August 26, 1974*)

OUTLINE OF CURRICULUM CONTENT

for

UNDERSTANDING CHILD MALTREATMENT: HELP AND HOPE

Unit I. The Phenomenon of Child Maltreatment

A. The phenomenon of child maltreatment is rooted in a long history of child abuse and child neglect in society.

1. Forms of child maltreatment in the past
2. Suggested reasons for child maltreatment in the past

B. Evidence today indicates that the phenomenon of child maltreatment is widespread in contemporary society.

1. Medical evidence of child maltreatment today
2. Psychological evidence of child maltreatment today
3. Statistical evidence of child maltreatment today
4. Sociological evidence of child maltreatment today

C. The phenomenon of child maltreatment is ascribed to be the symptom of a dysfunction within society, the family, or the individual which manifests itself when a child is physically or psychologically damaged.

1. Suggested areas of dysfunction within society
2. Suggested areas of dysfunction within the family
3. Suggested areas of dysfunction within the individual

Unit II. The Nature of Child Maltreatment

A. Child maltreatment is described as acts of physical abuse and/or neglect and acts of psychological abuse and/or neglect on the part of a caretaker.

   1. Federal definition of child maltreatment
   2. Identity of the caretaker
   3. Typical acts of physical and psychological abuse
   4. Typical acts of physical and psychological neglect which may result in damage to the child
   5. Typical acts of psychological abuse and/or neglect (without physical abuse and/or neglect) which may result in damage to the child.

B. Child Maltreatment is manifest in physical and psychological damage in the child.

   1. Typical manifestations (results) of physical abuse and neglect in the child.
   2. Typical manifestations (results) of psychological abuse and neglect in the child

C. Child maltreatment is distinguishable from acceptable or usual child-rearing practices in society today.

   1. Characteristics of acceptable child-rearing practices today
   2. Characteristics of child maltreatment today

Unit III. The Episode of Child Maltreatment

A. The episode of child maltreatment is attributed to a potentially abusive or neglectful caretaker, to a potentially vulnerable child, and to stress as the "triggering" mechanism.

B. The episode may also include a passive partner and/or sibling on-looker(s).

1. The role of the potentially abusive or neglectful caretaker
2. The role of the potentially vulnerable child
3. The role of stress as the "triggering" mechanism
4. The role of the passive partner
5. The role of the sibling on-looker(s)

C. The potentially abusive or neglectful caretaker is representative of a cross-section of any community in terms of race and/or social or economic status.

1. The potentially abusive or neglectful caretaker
2. Characteristics of the potentially abusive or neglectful caretaker

D. The potentially vulnerable child may be an exceptional or demanding child or a normal child.

1. The potentially vulnerable child
2. Characteristics of the potentially vulnerable child
3. Characteristics of the potentially vulnerable child from the viewpoint of the caretaker

E. Stress, the "triggering" mechanism may originate within society. the family, or the individual.

1. Definition of stress
2. Characteristics of stress in relation to time (duration)
3. Kinds of stress
4. Origins of stress

Unit IV. The Psychodynamics of Child Maltreatment

A. Child maltreatment is attributed to the psychodynamic interaction among the caretaker, the child, and the stress factor or stressor.

1. The definition of psychodynamics
2. Interaction viewed as an action (or reaction) in response to an influence, an event, or a person (past or present)
3. Psychodynamic interaction viewed as action (or reaction) of the child or the caretaker in response to
    a) An influence or influences (past or present)
    b) An event or events (past or present)
    c) A person or persons (past or present)
4. Psychodynamic interaction between the child and the caretaker viewed in relation to stress
    a) Within society
    b) Within the family
    c) Within the individual

B. The psychodynamic dimension of child maltreatment may be measured by the caretaker's conscious and/or unconscious actions or reactions to the child.

1. Conscious (re)actions viewed as (re)actions of the caretaker which are aware, deliberate, planned
2. Unconscious (re)actions viewed as (re)actions of the caretaker which are not consciously realized, planned, or done
3. Conscious and unconscious (re)actions of the caretaker in relation to stress
4. Typical conscious and unconscious (re)actions of the caretaker to the child

C. The psychodynamic dimension of child maltreatment may be measured b the child's conscious and/or unconscious actions or reactions to th caretaker (i.e., to maltreatment).

1. Conscious reactions defined as (re)actions of the child which are deliberate, planned, aware
2. Unconscious reactions defined as (re)actions of the child which are not consciously realized, planned, or done
3. Conscious and unconscious (re)actions of the child in relation to stress (i.e., maltreatment)
4. Typical conscious and unconscious (re)actions of the child to the caretaker (i.e., to maltreatment)

D. The psychodynamic dimension of child maltreatment may be measured in the recurring pattern or cycle of abuse and neglect within the same family from one generation to the next.

1. The potentially abusive or neglectful caretaker is often one who was abused or neglected in infancy or childhood:
    a) Deprived of a mothering or nurturing experience
    b) Conditioned toward violence in human behavior
2. The abused or neglected infant or child will frequently in adult life:
    a) Experience difficulty in the adult nurturing role
    b) Adopt violence as a way of life

Unit V. The Problem of Child Maltreatment

A. Child maltreatment may be described as circumstantial.

  1. Circumstantial child maltreatment, i.e., child maltreatment belonging to, consisting in, or dependent upon circumstances
  2. Circumstantial child maltreatment viewed in relation to dysfunctions within society
  3. Circumstantial child maltreatment viewed in relation to dysfunctions within the family
  4. Circumstantial child maltreatment viewed in relation to dysfunctions within the individual
  5. Circumstantial child maltreatment viewed in relation to individual ability to cope with stress

B. Child maltreatment may be described as incidental.

  1. Incidental child maltreatment, i.e., child maltreatment occurring merely by chance or without intention or calculation
  2. Incidental child maltreatment viewed in relation to dysfunctions within society
  3. Incidental child maltreatment viewed in relation to dysfunctions within the family
  4. Incidental child maltreatment viewed in relation to dysfunctions within the individual
  5. Incidental child maltreatment viewed in relation to individual ability to cope with stress

C. Child maltreatment may be described as intentional.

1. Intentional child maltreatment, i.e., child maltreatment which is done by intention or design
2. Intentional child maltreatment viewed in relation to dysfunctions within society
3. Intentional child maltreatment viewed in relation to dysfunctions within the family
4. Intentional child maltreatment viewed in relation to dysfunctions within the individual
5. Intentional child maltreatment viewed in relation to individual ability to cope with stress

D. Child maltreatment -- whether circumstantial, incidental, or intentional -- is defined by law.

1. Child maltreatment legislation
2. Current child maltreatment laws
    a) State law
    b) Local law
3. The local process for reporting child abuse
    a) Mandatory by law
    b) Identity not required
    c) Provision for immunity
    d) Authorized agencies
    e) Methods of investigation
    f) Registration of case
        1) Local
        2) Central
4. The local process for reporting child neglect

Unit VI. Child Maltreatment: Help and Hope

A. Through the individual's response to the problem of child maltreatment, there is help for the maltreated child.

1. How to respond:
    - a) Recognize child maltreatment.
        - 1) Indicators of child maltreatment
        - 2) Problems inhibiting personal involvement
    - b) Report child maltreatment.
2. Kinds of responses: Help for the child
    - a) Treatment or hospitalization
    - b) Individual and/or family therapy
    - c) Supervision at home
    - d) Court protection
    - e) Provision for alternative care

B. Through the individual's response to the problem of child maltreatment, there is help for the caretaker.

1. How to respond
    - a) Recognize child maltreatment.
        - 1. Indicators of child maltreatment
        - 2. Problems inhibiting personal involvement
    - b) Report child maltreatment.
2. Kinds of responses: Help for the caretaker
    - a) Counseling by the helping professional
        - 1) Medical practitioner, psychiatrist
        - 2) Social worker, mental health assistant
        - 3) Pastor, trained lay person

- b) Government Services
    - 1) Protective Service Agency
    - 2) Department of Welfare
    - 3) Department of Health
    - 4) The Judiciary
    - 5) Law enforcement agency
- c) Community support
    - 1. Parental Stress Service, Hot Lines
    - 2. Parents Anonymous, Families Anonymous
    - 3. Group therapy programs
    - 4. Residential programs
- d) Education
    - 1) Increased knowledge of self and others
    - 2) Parenting skills
    - 3) Home management skills
    - 4) Financial management skills
    - 5) Job training skills
    - 6) Other

C. Through society's response to the problem of child maltreatment, there is hope for prevention.

- 1. Those who must respond:
    - a) Enlightened parents
    - b) Concerned citizens
    - c) Alerted medical practitioners
    - d) Informed social workers, teachers, and law enforcement authorities
    - e) Dedicated legislators and social policy makers

2. Kinds of responses: Hope for prevention

   a) Recognition and protection of the rights of children

   b) Improved environment for children

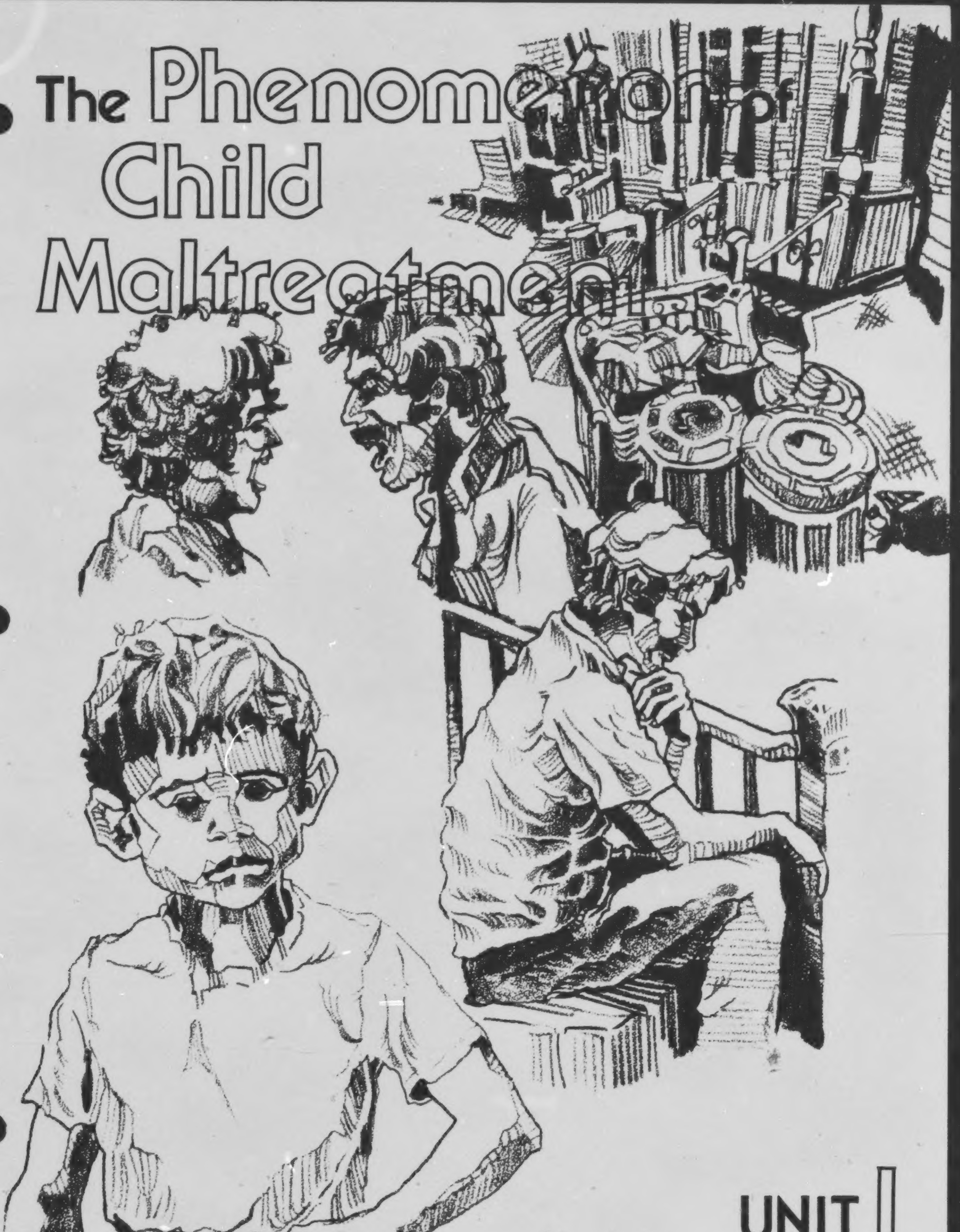
   c) Greater dissemination of knowledge about child maltreatment

   d) Adequate funding for child maltreatment prevention programs

   e) Increase in available community resources and services for both the maltreated child and the caretaker

   f) More compassionate understanding of the problem of child maltreatment

The Phenomenon of Child Maltreatment



UNIT I

I. The PHENOMENON of CHILD MALTREATMENT

--- What Is It?

What seek ye fellow citizens
that you turn every stone
to scrape wealth together
YET take such little heed
to your children to whom
ye must one day relinquish all.
Socrates

UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective

The student will be able to compare the historical and contemporary phenomenon of child maltreatment in society.

Performance Objectives for Generalization A

1. DESCRIBE forms of child maltreatment in the past
2. LIST possible reasons for child maltreatment in the past.

Generalization A

THE PHENOMENON OF CHILD MALTREATMENT IS ROOTED IN A LONG HISTORY OF CHILD ABUSE AND CHILD NEGLECT IN SOCIETY.

Sample Content

1. Forms of child maltreatment in the past
   - a) Accepted (or current) child-rearing practice
   - b) Exploitation
   - c) Mutilation
   - d) Abandonment
   - e) Death (infanticide/sacrifice)
2. Suggested reasons for child maltreatment in the past
   - a) Custom or tradition
   - b) Economic usefulness
   - c) Lawful right
   - d) Tribal or cultural practice
   - e) Religious belief

UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective for Unit I

THE STUDENT WILL BE ABLE TO COMPARE THE HISTORICAL AND CONTEMPORARY PHENOMENON OF CHILD MALTREATMENT IN SOCIETY.

Generalizations for Unit I

A. The phenomenon of child maltreatment is rooted in a long history of child abuse and child neglect in society.

B. Evidence today indicates that the phenomenon of child maltreatment is widespread in contemporary society.

C. The phenomenon of child maltreatment is ascribed to be the symptom of a dysfunction within society, the family, or the individual which manifests itself when a child is physically or psychologically damaged.

Performance Objectives for Unit I

1. DESCRIBE forms of child maltreatment in the past.
2. LIST possible reasons for child maltreatment in the past.
3. CITE medical and psychological evidence of child maltreatment in society today.
4. CITE statistical evidence of child maltreatment in society today.
5. CITE sociological evidence of child maltreatment in society today.
6. IDENTIFY dysfunctions within society which could result in a physically or psychologically damaged child.
7. IDENTIFY dysfunctions within the family which could result in a physically or psychologically damaged child.
8. IDENTIFY dysfunctions within the individual which could result in a physically or psychologically damaged child.

Suggested Classroom Activities and Procedures for Performance Objectives 1 and 2

1. Have students read and discuss in class "Our Forebears Made Childhood a Nightmare" (I.2).
2. Clarify student understanding of the terms phenomenon and maltreatment in the Definition of Terms (I.1).
3. Introduce Generalization I A and write on board for students.
4. List on board the forms of child maltreatment in the past as noted in I A Sample Content 1.
5. Have students suggest examples from history for each of the forms of child maltreatment noted in the past.
6. Discuss nursery rhymes and fairy tales in oral tradition as evidences of child maltreatment in the past.
7. Correlate for students forms of child maltreatment in the past with the corresponding reason, or reasons, for child maltreatment as noted in I A Sample Content 2.
8. Have students read and discuss in class "Who Owns the Child?" (I.3).
9. Relate current child protection laws to forms and suggested reasons for historical phenomenon of child maltreatment.
10. Have students read and discuss "'Good Children' (Our Own), 'Bad Children' (Other People's) and the Horrible Work Ethic" (I.8) in relation to factors which influence the attitude of society toward children.
11. Discuss child welfare legislation in relation to forms of child maltreatment in the past.

12. Emphasize that since 1960 new child maltreatment legislation has been passed in an effort to cope with forms of the phenomenon which exist today.

13. Students may

- Write summary paragraphs of I.2, I.3, or I.8.
- Research and write a brief paper on fairy tales or nursery rhymes as evidences of child maltreatment in the past. Example: Hansel and Gretel (abandonment/competition for food)
- Research and write a brief paper on child labor laws in relation to child maltreatment in the past.
- Survey teachers in appropriate subject areas for examples of child maltreatment in art, literature, history.
- Invite Child Development teacher to talk about child-rearing practices in the past which are now thought harmful and are no longer practiced.
- Debate the following: Is Child Maltreatment Today the Same as, or Different from Child Maltreatment in History?
- Pursue in-depth study of recent child abuse and child neglect legislation. See Unit V D.

14. Conclude with assessment measures for Performance Objectives 1 and 2.

UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective

The student will be able to compare the historical and contemporary phenomenon of child maltreatment in society.

Performance Objectives for Generalization B

3. CITE medical and psychological evidence of child maltreatment today.
4. CITE statistical evidence of child maltreatment today.
5. CITE sociological evidence of child maltreatment today.

Generalization B

EVIDENCE TODAY INDICATES THAT THE PHENOMENON OF CHILD MALTREATMENT IS WIDESPREAD IN CONTEMPORARY SOCIETY.

Sample Content

1. Medical evidence of child maltreatment today (For in-depth study, see Unit II.)
    - a) Definition of the "child maltreatment syndrome"
    - b) Pathological evidence in the child
    - c) Radiological evidence in the child
2. Psychological evidence of child maltreatment today (For in-depth study, see IV A.)
3. Statistical evidence of child maltreatment today
    - a) National
    - b) State
    - c) County or municipal
4. Sociological evidence of child maltreatment today
    - a) Geographical distribution (urban/rural)
    - b) Economic strata
    - c) Social class
    - d) Educational level
    - e) Ethnic background
    - f) Sex

Suggested Classroom Activities and Procedures for Performance Objective 3

1. Use a brief lecture to introduce students to the contemporary phenomenon of child maltreatment. Discuss the role of the x-ray in diagnosing child maltreatment.
2. Have students view film Children in Peril.
3. Introduce Generalization I B Sample Content 1. and 2. Write on board for students.
4. Clarify student understanding of the term "syndrome." See Definition of Terms (I.1). Explain "signs" as objective evidence; "symptoms" as subjective evidence.
5. Clarify student understanding of the terms "pathological," "radiological," and "psychological." See Definition of Terms (I.1).
6. Restate the definition of the child maltreatment syndrome as "a group of [pathological, radiological, and/or psychological] signs and symptoms [in the child] which characterize a particular abnormality [maltreatment]."
7. Show Transparency 10 for examples of pathological and radiological evidence (signs or symptoms) in the maltreated child.
8. Show Transparency 11 a and b for examples of psychological evidence (signs or symptoms) in the maltreated child. Emphasize NOTE on Transparency.
9. Students may
   - Read and write a brief paper on selected items in the Classroom Learning Center.
   - Pursue in-depth study of the psychological evidence of child maltreatment. (See Unit IV.)

- Invite a member of the Montgomery County Child Protection Team to talk about Characteristics of the Vulnerable Child (III.5).
- Interview a member of the Special Child Abuse Team, Children's Hospital, on how to recognize child maltreatment.

10. Conclude with assessment measures for Performance Objective 3.

Suggested Classroom Activities and Procedures for Performance Objectives 4 and

1. Restate Generalization I B and write on board for students.
2. Write I B Sample Content 3 and 4 in outline form beneath Generalization I B.
3. Conduct class discussion, using Questions and Answers (I.4).
4. Show Transparency 1, depicting national statistics.
5. Analyze for students the methods used by the Mershon Center to obtain national statistics. See "Child Abuse and Neglect Programs: A National Overview" (I.5).
6. Discuss the possible relationship of statistics on accidental death of children to national statistics for unreported cases of child maltreatment.
7. Emphasize that statistics on child maltreatment vary with public awareness of the problem. Refer students to "Child Abuse Reports Have Increased Since 1972" (I.7).
8. Review current statistics for child abuse and neglect for the State of Maryland.
9. Show Transparencies 2,3,4, depicting county statistics. Discuss possible significance of age peaks.

10. Discuss sociological aspects, I B Sample Content 4, of child maltreatment in relation to sociological characteristics of Montgomery County. See also Questions and Answers (I.4).

11. Write Unit III Generalization C. on board. Use as basis to summarize discussion: "The potentially abusive or neglectful caretaker is representative of a cross-section of any community in terms of race and/or social or economic status."

12. Students may:
    - Read and discuss in class "Child Abuse and Neglect Programs: A National Overview" (I.5).
    - Make a collage illustrative of the sociological aspects of child maltreatment.
    - Draw color charts illustrative of statistics for the State of Maryland.
    - Read and write a brief summary of selected articles from the classroom learning center for child maltreatment.
    - Research current statistics (previous months) for reported cases of suspected child maltreatment in Montgomery County.
    - Group discuss the question: "Why is child maltreatment a widespread phenomenon in contemporary society?" and report conclusion to class.
    - Invite a resource speaker to talk about The Potentially Abusive or Neglectful Caretaker (III.3)
    - View and discuss film Fragile: Handle With Care (where available) in relation to how future generations of children can be freed from such peril.

13. Conclude with assessment measures for Performance Objectives 4, 5.

UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective

The student will be able to compare the historical and contemporary phenomenon of child maltreatment in society.

Performance Objectives for Generalization C

6. IDENTIFY dysfunctions within society which could result in a physically or psychologically damaged child.
7. IDENTIFY dysfunctions within the family which could result in a physically or psychologically damaged child.
8. IDENTIFY dysfunctions within the individual which could result in a physically or psychologically damaged child.

Generalization C

THE PHENOMENON OF CHILD MALTREATMENT IS ASCRIBED TO BE THE SYMPTOM OF A DYSFUNCTION WITHIN SOCIETY, THE FAMILY, OR THE INDIVIDUAL WHICH MANIFESTS ITSELF WHEN A CHILD IS PHYSICALLY OR PSYCHOLOGICALLY DAMAGED.

Sample Content

1. Suggested areas of dysfunction within society:
    - a) Economic conditions
    - b) Environmental conditions
    - c) Social values
    - d) Institutions
    - e) Others
2. Suggested areas of dysfunction within the family:
    - a) Intra-familial relationships
    - b) Child-rearing practices
    - c) Family structure
    - d) Life style
3. Suggested areas of dysfunction within the individual:
    - a) Physical incapacity or inability
    - b) Psychological (emotional) incapacity or inability
    - c) Mental incapacity or inability
    - d) Others

Suggested Classroom Activities and Procedures for Performance Objectives 6, 7, and 8

1. Review Generalization I A, Sample Content 1 and 2.
2. Introduce Generalization I C and write on board for students.
3. Clarify student understanding of the term dysfunction in relation to society, the family, and the individual.
4. Write "Historical Phenomenon of Child Maltreatment" on board.
5. Have students suggest:

   Dysfunctions of society (in the past) which resulted in the phenomenon of child maltreatment

   Dysfunctions of the family (in the past) which resulted in the phenomenon of child maltreatment

   Dysfunctions of the individual (in the past) which resulted in the phenomenon of child maltreatment
6. Write "Contemporary Phenomenon of Child Maltreatment" on the board.
7. Suggest class divide into three discussion groups to represent society, the family, and the individual. Have a volunteer or assigned leader for each group.
8. Direct class attention to Dysfunctions of Society, the Family, and the Individual (I.6) as a discussion aid.
9. Suggest each group develop an appropriate list of dysfunctions of society, the family, or the individual which might contribute to the phenomenon of child maltreatment today.

10. Have students read instructional material I.9 through I.14.

11. Have each group report and compare its list with the list on board of dysfunctions in the past which resulted in the historical phenomenon of child maltreatment.

12. Show Transparency 16 a, b, c and Transparency 17 a, b as a check list.

13. Students may roundtable discuss:

    . If child maltreatment is ascribed to be the symptom of a dysfunctioning of society, what positive actions can society take today to prevent child maltreatment? See Generalization V D and Generalization VI C.

    . If child maltreatment is ascribed to be the symptom of a dysfunctioning of the family, what positive actions can be taken by families today to prevent child maltreatment? Generalization V D and Generalization VI A and V B.

    . If child maltreatment is ascribed to be the symptom of a dysfunctioning of the individual, what positive actions can be taken by the individual today to prevent child maltreatment? See Generalization V D and VI A, B, C.

14. Have students survey psychology, history, or sociology teachers for further examples of dysfunction in society, the family, or the individual which could result in a physically or psychologically damaged child.

15. Conclude with assessment measures for Performance Objectives 6, 7, and 8.

EVALUATION

for

I. The Phenomenon of Child Maltreatment

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1 AND 2 -- UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective: The student will be able to compare the historical and contemporary phenomenon of child maltreatment in society.

Generalization A Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
1. DESCRIBE forms of child maltreatment in the past.	Listed below are ________ forms of child maltreatment in the past. Describe ________ examples for each form listed.	I A Sample Content 1 I.1 I.2 I.3 I.8
2. LIST possible reasons for child maltreatment in the past.	Listed below are ________ examples of child maltreatment in the past. Suggest a possible reason or reasons for each example. 1. Begging ____________ 2. Tattooing ____________ 3. Killing ____________ 4. Swaddling ____________ 5. Wet nursing ____________ 6. Abandoning ____________ 7. Foot binding ____________ 8. Others	I A Sample Content 2 I.1 I.2 I.3 I.8

Key Word[1] (See Appendix A.)

DESCRIBE - to state a verbal picture or / to/ list the characteristics of a person, place, thing, or event

LIST - to make a series of words or statements

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[1] Thomas Evaul, Behavioral Objectives, Their Rationale and Development (Merchantville, New Jersey: Curriculum and Evaluation Consultants) 1972.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 3 AND 4 --
UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective: The student will be able to compare the historical and contemporary phenomenon of child maltreatment in society.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
3. CITE medical and psychological evidence of child maltreatment today.	Define the child maltreatment syndrome. Name and define two kinds of medical evidence observable in the maltreated child. Give ____ examples of each. Give _____ examples of psychological evidence observable in the maltreated child.	I B Sample Content 1 and 2 I.1 III.5 Transparency 10 Transparency 11 a, b Film Children in Peril
4. CITE statistical evidence of child maltreatment today.	Arrange in order of importance the following causes of childhood deaths annually: 1. 4. 2. 5. 3. a) cancer b) accidents c) heart disease d) influenza e) child abuse Fill in blanks: a) National statistics on child maltreatment vary because ____________. b) ___________ reported (State/County) _____ cases of suspected (number) child abuse in _____. (year)	I B Sample Content 3 and 4 I.4 I.5 I.7 III C Transparency 1, 2, 3, 4

Key Word[2] (See Appendix A.)
CITE - to quote information from an external source for the purpose of clarifying something (e.g., cite examples, data)

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[2] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVE 5 --
UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective: The student will be able to compare the historical and contemporary phenomenon of child maltreatment in society.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
5. CITE sociological evidence of child maltreatment today.	TRUE/FALSE 1) There is more abuse than neglect of children.	I B Sample Content 3 and 4
	2) More women than men abuse younger children.	I.4 I.5 I.7
	3) Older children are more likely than younger children to be maltreated.	III.3 III C
	4) Child maltreatment occurs more often in lower socio-economic levels.	Transparency 1, 2, 3, 4
	5) Children in rural areas are less likely to be maltreated than those in urban areas.	

Key Word[3] (See Appendix A.)

CITE - to quote information from an external source for the purpose of clarifying something (e.g., cite examples, data)

[3] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 6, 7, AND 8 --
UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective: The student will be able to compare the historical and contemporary phenomenon of child maltreatment in society.

Generalization C Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by itemizing the resources listed below:
6. IDENTIFY dysfunctions within society which could result in a physically or psychologically damaged child.	Identify _____ broad areas of dysfunction within society which could result in a physically or psychologically damaged child. Give _____ examples of each.	I C Sample Content 1 I.1 I.6 I.9 through I.14 V D VI A VI B VI C Transparency 16 a, b, c Transparency 17 a, b
7. IDENTIFY dysfunctions within the family which could result in a physically or psychologically damaged child.	Identify _____ broad areas of dysfunction in the family which could result in a physically or psychologically damaged child. Give _____ examples of each.	I C Sample Content 2 I.1 I.6 I.9 through I.14 V D VI A VI B VI C Transparency 16 a, b, c Transparency 17 a, b
8. IDENTIFY dysfunctions within the individual which could result in a physically or psychologically damaged child	Identify _____ broad areas of dysfunction in the individual which could result in a physically or psychologically damaged child. Give _____ examples of each.	I C Sample Content 3 I.1 I.6 I.9 through I.14 V D VI A VI B VI C Transparency 16 a, b, c Transparency 17 a, b

Key Word[4] (See Appendix A.)

IDENTIFY - to select from among several choices the item(s) that meet(s) certain criteria

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[4] Evaul.

CLASS RECORD FORM

S = SATISFACTORY
U = UNSATISFACTORY

UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

CLASS ____________________

PERIOD __________

INSTRUCTIONAL OBJECTIVE: The student will be able to compare the historical and contemporary phenomenon of child maltreatment in society.

NAME	PERFORMANCE OBJECTIVE								AVERAGE %	
	1	2	3	4	5	6	7	8	S	U
AVERAGE % S										
U										

CLASS AVERAGE

GRADE KEY

S----SATISFACTORY for PERFORMANCE OBJECTIVES

U----UNSATISFACTORY for PERFORMANCE OBJECTIVES

60% SATISFACTORY = CREDIT for COURSE

STUDENT ______________________

FINAL GRADE

TOTAL % SATISFACTORY for COURSE _____

TOTAL % UNSATISFACTORY for COURSE _____

INDIVIDUAL STUDENT RECORD

	PERFORMANCE OBJECTIVES																	AVERAGE % Instructional Objectives S	U
UNIT I Instructional Objective	1	2	3	4	5	6	7	8											
UNIT II Instructional Objective	1	2	3	4	5	6	7	8	9	10									
UNIT III Instructional Objective	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
UNIT IV Instructional Objective	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17		
UNIT V Instructional Objective One	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
UNIT V Instructional Objective Two	1	2	3	4	5														
UNIT VI Instructional Objective One	1	2	3	4															
UNIT VI Instructional Objective Two	1	2																	

CLASSROOM INSTRUCTIONAL MATERIAL

for

I. The Phenomenon of Child Maltreatment

SELECTED RESOURCES

1. Definition of Terms (I.1)
2. "Our Forebears Made Childhood a Nightmare" (I.2)
3. "Who Owns the Child?" (I.3)
4. Questions and Answers About Child Maltreatment (I.4)
5. "Child Abuse and Neglect Programs: A National Overview" (I.5)
6. Dysfunctions in Society, the Family, and the Individual (I.6)
7. "Child Abuse Reports Have Increased Since 1972" (I.7)
8. "Good Children' (Our Own), 'Bad Children' (Other People's), and the Horrible Work Ethic" (I.8)
9. "Is U.S. Becoming Less Child-Oriented?" (I.9)
10. "Imprisoning Our Children" (I.10)
11. "They've No Right To Destroy the Children" (I.11)
12. "Medical Care Lacking for Children of Poor" (I.12)
13. "Shipping Children South" (I.13)
14. "Child-Snatching" (I.14)
15. Classroom Learning Center for Child Maltreatment

AUDIOVISUAL MATERIAL

Overhead Transparencies

1. Table 1, Mershon Study Center
2. Age Profile 1974-75, Reports of Suspected Child Abuse, MCPS
3. Sex and Mean Age of Children Reported, MCPS
4. Age Profiles Compared, 1973-74 and 1974-75, MCPS

FILM

Children in Peril. Discusses causes of child abuse and programs developed for treatment of child abusers. S. T 22 min. color 1. Child abuse. EMC 362.7 5684 Media Concepts 1972.

Fragile, Handle with Care. A film of stark realism which tells of the death of an infant brought to the emergency ward time after time by its young parents before finally succombing to maltreatment. The film delves into the reasons why parents abuse their children, and what happens to the children mentally and physically. It also looks into ways of preventing child abuse, the legal considerations involved, and the professional help that is available for children.

A KTAR TV film produced in cooperation with The Independent Order of Foresters 16mm color 26 min. Available on loan from Independent Order of Foresters, 10215 Reisterstown Road, Owings Mills, Maryland 21117.

I. THE PHENOMENON OF CHILD MALTREATMENT

*DEFINITION OF TERMS (I.1)

1.	Phenomenon	n.	- 3.b. an exceptional, unusual, or abnormal person, thing, or occurence
2.	Maltreat Maltreatment	vt. n.	- to treat cruelly or roughly
3.	Syndrome	n.	- a group of signs and symptoms that occur together and characterize a particular abnormality
4.	Radiological	adj.	- of or pertaining to the use of radiology (X-ray)
5.	Pathological Pathology	adj. n.	- 2: altered or caused by disease 2 a: anatomic and physiologic deviations from the normal that constitute disease or characterize a particular disease
6.	Dysfunction	n.	- impaired or abnormal functioning

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* Webster's New Collegiate Dictionary. Springfield, Massachusetts: S & C Merriam Co.

Empathy for Children

Our Forebears Made Childhood a Nightmare

From antiquity's infanticide to 19th-century manipulation, the human track record on child-raising is bloody, dirty and mean. Only lately, and only now in small numbers, do parents feel that children need aid and comfort, not brutality.

by Lloyd DeMause

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Psychology Today Magazine

FOR MOST PEOPLE IN OUR SOCIETY, infants and children are small people to whom we should try to offer aid and comfort whenever possible. This attitude is new. A search of historical sources shows that until the last century children were instead offered beatings and whippings, with instruments usually associated with torture chambers. In fact, the history of childhood is a nightmare from which we have only recently begun to awaken.

The newness of the ability to feel empathy toward children is clear from a five-year study that my colleagues and I have just completed. The further back in history we went, the lower the level of child care we found, and the more likely children were to have been killed, abandoned, whipped, sexually abused and terrorized by their caretakers.

A child's life prior to modern times was uniformly bleak. Virtually every child-rearing tract from antiquity to the 18th century recommended the beating of children. We found no examples from this period in which a child wasn't beaten, and hundreds of instances of not only beating, but battering, beginning in infancy.

One 19th-century German schoolmaster who kept score reported administering 911,527 strokes with a stick, 124,000 lashes with a whip, 136,715 slaps with his hand and 1,115,800 boxes on the ear. The beatings described in most historical sources began at an early age, continued regularly throughout childhood, and were severe enough to cause bruising and bloodying. It took centuries of progress in parent-child relations before the West could begin to overcome its apparent need to abuse its children.

Personality, Not Technology. I believe that the major dynamic in historical change is ultimately neither technology nor economics. More important are the changes in personality that grow from differences between generations in the quality of the relationship between parent and child. Good parenting is something that has been achieved only after centuries as generation after generation of parents tried to overcome the abuse of their own childhoods by reaching out to their children on more mature levels of relating.

Throughout history, an adult has had three major reactions to a child who needs its care. The projective reaction consists of using the child as a receptacle for the adult's unconscious feelings. The reversal reaction occurs when the adult uses the child as a substitute for an adult figure who was important in his own childhood. The empathic reaction, a late historical acquisition, occurs if the adult is able to empathize with and satisfy the child's needs.

The first two reactions occurred simultaneously in parents in the past, producing a strange double image of the child in which it was at once both bad (projective) and needed (reversal). The further back in history you look, the more evident are these reactions and the more bizarre the prevailing attitudes toward children.

Century after century of battered children grew up and battered their own children in turn. John Milton's wife complained that she hated to hear the cries of his nephews as he beat them. Beethoven whipped his piano pupils with a knitting needle. Even royalty was not exempt—little Louis XIII was whipped upon awakening for his previous day's misdemeanors.

Even infants were often beaten. John Wesley's wife Susannah said of her babies, "When turned a year old (and some before), they were taught to fear the rod, and to cry softly." Rousseau reported that young babies were often beaten to keep them quiet. An early American mother wrote of her battle with her four-month-old infant: "I whipped him 'til he was actually black and blue, and until I *could not* whip him any more, and he never gave up one single inch."

Salted and Swaddled. If the newborn was allowed to live, parents would salt it and then bathe it in ice water to "harden" it. The baby was tied up tightly in swaddling bands for its first year, supposedly to prevent it from tearing off its ears, breaking its legs, touching its genitals or crawling around like an animal. Traditional swaddling, as one American doctor described it, "consists in entirely depriving the child of the use of its limbs by enveloping them in an endless bandage, so as to not unaptly resemble billets of wood, and by which the skin is sometimes excoriated, the flesh compressed, almost to gangrene . . ."

Swaddled infants were not only more convenient to care for, since they withdrew into themselves in sleep most of the day, but they were also more easily laid for hours behind hot ovens, hung on pegs on the wall, and, wrote one doctor, "left, like a parcel, in every convenient corner." In addition, they were often thrown around like a ball for amusement. In 16th-century France, a brother of Henri IV, while being tossed from one window to another, was dropped and killed. Doctors complained of parents who broke the bones of their children in the "customary" tossing of infants. Nurses often said that the stays that encased children beneath their swaddling hands were necessary because they could not "be tossed about without them"

Adults in the past, like contemporary child batterers, regularly succumbed to urges to mutilate, burn, freeze and drown infants. The Huns used to cut the cheeks of newborn males, Italian Renaissance parents would "burn in the neck with a hot iron, or else drop a burning wax candle" on newborn babies, and it was common to cut the string under the newborn's tongue, often with the midwife's fingernail. In every age, the deliberate mutilation of children's bones and faces prepared them for a lifetime of begging.

As late as the 19th century in Eastern Europe, baptism was not a matter of simple sprinkling, but an ice-water ordeal that often lasted for hours and sometimes caused the death of the infant. The regular practice of the plunge bath involved nearly drowning the infant over and over again in ice-cold water "with its mouth open and gasping for breath." The dipping of infants in cold rivers has been considered therapeutic since Roman times and, as late as the 19th century, children were often put to bed wrapped in cold wet towels to make them hardy. With such beginnings, it is not surprising that 18th century pediatrician William Buchan said "almost one half of the human species perish in infancy by improper management or neglect."

Although there were many exceptions to the general pattern, the average child of parents with some wealth spent his earliest years in the home of a wet nurse, returned home at age three or four to the care of other servants, and was sent out to service, apprenticeship, or school by age seven, so that the amount of time parents of means actually spent raising their children was minimal.

Since antiquity, wet nurses have been acknowledged to have been thoroughly unreliable—Jacques Guillimeau described how the child at nurse might be "stiffled, overlaid, be let fall, and so come to an untimely death, or else may be devoured, spoiled, or disfigured by some wild beast." A clergyman told one British doctor about his parish which was "filled with suckling infants from London, and yet, in the space of one year, he buried them all except two." Of 21,000 children born in Paris in 1780, 17,000 were sent into the country to be wet-nursed, 3,000 were placed in nursery homes, 700 were wet-nursed at home and only 700 were nursed by their own mothers. Even those mothers who kept their infants at home often did not breastfeed them, giving them pap (water and grain) instead. One 15th-century mother, who had moved from an area in which nursing infants was common, was called "swinish and filthy" by her Bavarian neighbors for nursing her child herself, and her husband threatened to stop eating if she did not give up this "disgusting habit."

Terrors of the Night. As the child grew out of swaddling clothes, parents found it terribly frightening to care for, having projected their own unconscious needs into the child. As a result, children were always felt to be on the verge of turning into actual demons, or at least to be easily susceptible to "the power of the Devil." To keep their small devils cowed, adults regularly terrorized them with a vast army of ghostlike figures, from the Lamia and Striga of the ancients, who ate children raw, to the witches of Medieval times, who would steal bad children away and suck their blood. One 19th-century tract described in simplified language the tortures God had in store for children in Hell: "The little child is in this red-hot oven. Hear how it screams to come out. It stamps its little feet on the floor." The need to personify punitive figures was so powerful that this terrorizing of children did not stop at imaginary figures. Dummies were actually made up to be used in frightening children. One English writer, in 1748, describes how:

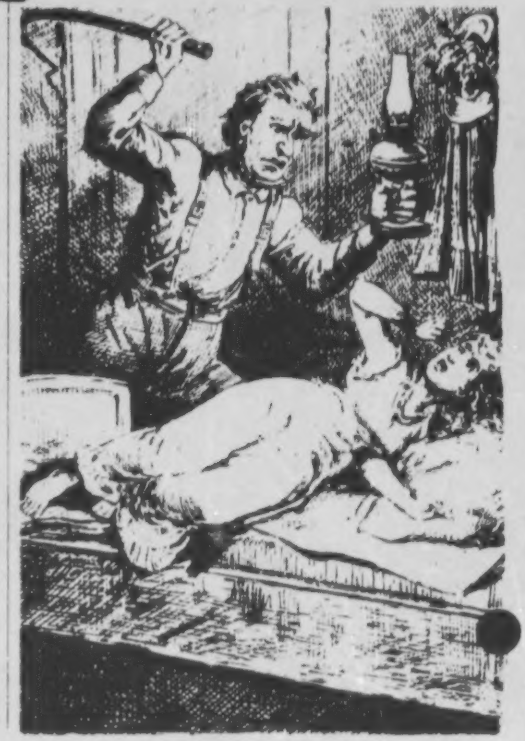
"The nurse takes a fancy to quiet the peevish child, and with this intent, dressed up an uncouth figure, makes it come in, and roar and scream at the child in ugly disagreeable notes, which grate upon the tender organs of the ear, and at the same time, by its gesture and near approach, makes as if it would swallow the infant up."

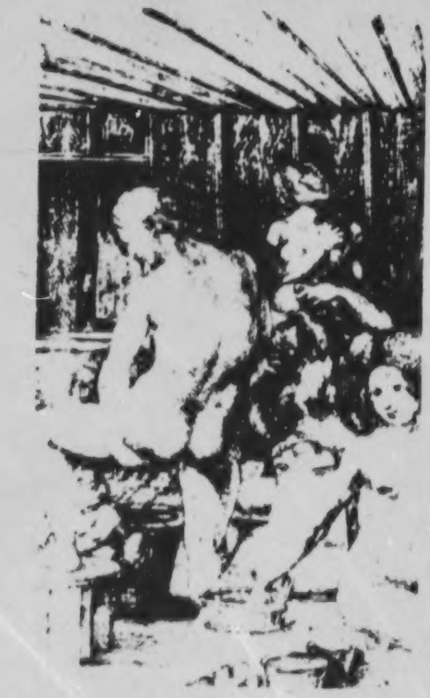
Another method that parents used to terrorize their children employed corpses. A common moral lesson involved taking children to visit the gibbet, where they were forced to inspect rotting corpses hanging there as an example of what happens to bad children when they grow up. Whole classes were taken out of school to witness hangings, and parents would often whip their children afterwards to make them remember what they had seen.

Sexual Abuse. The sexual abuse of children was also far more prevalent in the past than it is today. Growing up in Greece and Rome often included being used sexually by older men. Boy brothels flourished in every city in antiquity, and slave boys were commonly kept for homosexual use. Sexual abuse by pedagogues and teachers of small children was a common complaint, and even Aristotle thought that adult homosexuality must be a result of "those who are abused from childhood."

Erotic drawings often show nude children waiting on adults in sexual embrace, and Quintilian said that even noble children "hear us use such words, they see our mistresses and minions, every dinner party is loud with foul songs, and things are presented to their eyes of which we should blush to speak." Tiberius "taught children of the most tender years, whom he called his *little fishes*, to play between his legs while he was in his bath. Those which had not yet been weaned, but were strong and hearty, he set at fellatio." Castrated children were considered as especially arousing in antiquity, and infants were often castrated in the cradle for use in brothels.

The sexual use of children continued until early modern times. Servants were

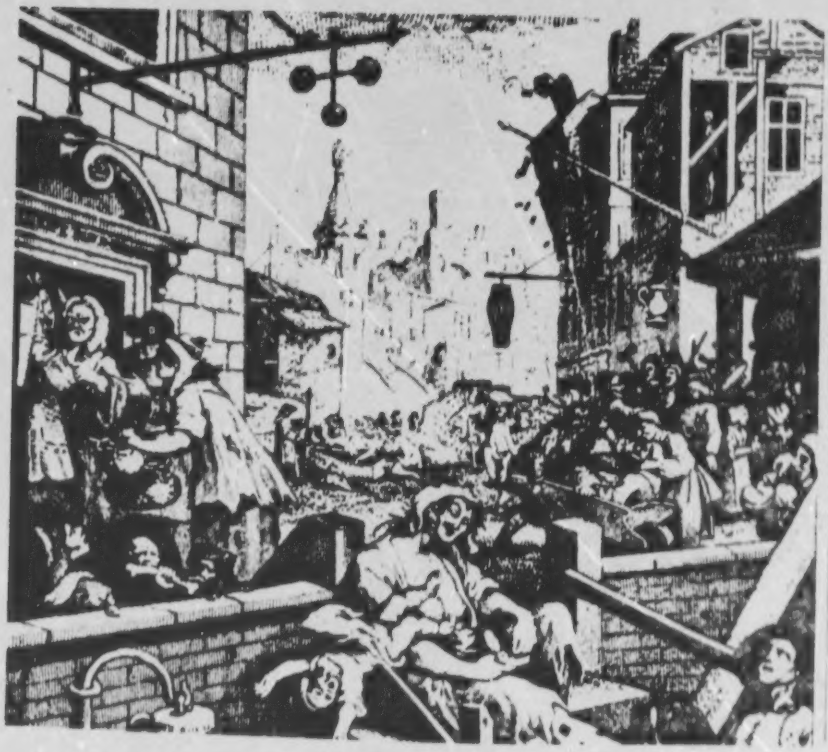




commonly known to be child molesters, and even parents would masturbate their children "to make their yards grow longer" Little Louis XIII was often hauled into bed by his parents and others and included in their sexual acts By the 18th century, however, parents began instituting severe punishments for childhood sensuality, perhaps in an unconscious maneuver to control their own sexual desires By the 19th century, parents and doctors began waging a frenzied campaign against childhood masturbation, threatening to cut off the child's genitals, performing circumcision and clitoridectomy without anesthesia as punishment, making children wear spiked cages and other restraints, and opening anti-masturbation sanatoria all over Europe

Good News. Despite the bleakness of this general historical picture of childhood, there is good evidence that childrearing modes have continuously evolved over the past two millennia in the West. An independent source of change lies within the parent-child relationship itself, as each generation of parents attempts anew to go beyond the abuses to which it has been subjected, producing a psychological advance in each period of history

Consider, for instance, the long struggle against infanticide. In antiquity infanticide was so common that every river, dung-heap and cesspool used to be littered with dead infants Polybius blamed the depopulation of Greece on the killing of legitimate children, even by wealthy parents. Ratios of boys to girls in census figures ran four to one, since it was rare for more than one girl in a family to be spared. Christians were considered odd for their opposition to infanticide, although even that opposition was mild, with few penalties Large-scale infanticide of legitimate babies continued well into Medieval times with boy-girl ratios in rich as well as poor families often still running two to one As late as 1527, one priest admitted that "the latrines resound with the cries of children who have been plunged into them" Yet infanticide was increasingly confined to the killing of illegitimate babies, and there is similar evidence of a continuous decrease in beating and other abusive practices through the centuries.



Evolutionary Trends. The following six evolutionary modes seem to describe the major trends of parent-child relations in the more advanced parts of the West:

INFANTICIDAL MODE (ANTIQUITY) The image of Medea hovered over childhood in antiquity, not only because parents resolved their anxieties about taking care of children by infanticidal acts, but also because the lives of those children who were allowed to live were constantly threatened by severe abuse

ABANDONMENT MODE (MEDIEVAL) The parents who accepted the right of the child to live but whose immaturity made them still unable to care for it abandoned the child either to a wet nurse foster family, monastery, nunnery, other home (as servants) or simply through severe emotional neglect by the parents themselves

AMBIVALENT MODE (RENAISSANCE) closer relationship with the child pr duced ambivalent parents, fearful th their child's insides were full of evil s that they had to be purged with contin uous enemas, yet close enough to expre both love and hate, often in bewilderin juxtaposition

INTRUSIVE MODE (18TH CENTURY) A d

crease of ambivalence now enabled the parent actually to make the intrusive control of the child's insides part of their own defense system. The child was no longer so full of dangerous projections, and was therefore not swaddled, nor sent out to wet-nurse, nor given enemas, but was instead toilet-trained, prayed with but not yet played with, and disciplined as much through guilt as by beating. As empathy grew, pediatrics could be invented, and the general improvement in child care reduced infant mortality greatly.

SOCIALIZING MODE (19TH CENTURY TO NOW). Still the major mode of parents today, socializing involves thinking of the child as someone who needs continuous training and guidance in order to become civilized. Most discussions of child care still take place within the socializing mode, and it has been the source of all contemporary models of the psyche from Freud to Skinner. In practice, it involves giving up most of the severe beating and other overt forms of abuse while using covert methods of manipulation, guilt, and a general detached quality of parenting to sustain the long periods of contact with children whose increasing needs are simply too much for the parents.

HELPING MODE (JUST BEGINNING). The helping mode starts with the proposition that the child knows better than the parent what it needs at each stage of its life, and involves both parents fully in the child's daily life as they help it with its expanding needs. The helping mode requires enormous time, energy and emotional maturity on the part of both parents, especially in the first six years of the child's life, as they play with it, tolerate its regressions, and discuss its needs and conflicts in an effort to keep pace with its emotional and intellectual growth.

Studies of contemporary American families show children being cared for by parents included in all six of these modes. In fact, when psychiatrists arrange family types on a scale of decreasing health, they are actually listing historical modes of childrearing, with the lower part of the scale describing parents who behave like evolutionary arrests, psychological fossils stuck in personality modes from a previous historical period when most parents used to batter children. The finding that most child abusers were themselves abused as children supports this picture.

Even though childhood for many is now more humane than at any other time in history, functional equivalents of earlier modes remain with us. Children are not sent out to wet nurses at birth, or to be servants at seven, but we do abandon them to hosts of nurseries, teachers, camps, and baby sitters for major portions of their young lives. Intrusive parents still find ways to restrict their baby's movements, much as swaddling and corsets did, and parents continue to emotionally abandon, betray, manipulate and hurt their children both overtly and covertly.

Because psychic structure is passed from generation to generation through the narrow gap of childhood, the childrearing practices of a society are more than just another item on a list of cultural traits. The history of childhood in fact determines which elements in all the rest of history will be transmitted and which will be changed. By studying the history of childhood we can gain an understanding of the personality traits on which our adult society rests, and perhaps even alter those historical group fantasies like war that threaten us most.

Lloyd deMause is Founder and Editor of *History of Childhood Quarterly. The Journal of Psychohistory.* DeMause studied history at Co-

lumbia University and psychoanalysis at the National Psychological Association for Psychoanalysis. He is also on the training staff at the New York Center for Psychoanalytic Training and is past Executive Secretary of the Association for Applied Psychoanalysis. He is co owner of The Psychohistory Press.

No Battered-Baboon Syndrome

Infant T.L.C., Simian Style

Lunchtime with your local baboons is pretty much a free-for-all. Dominant animals corral and consume their favorite foods while the more submissive ones lose out and display their disgust by threatening and chasing each other. Eventually everyone eats, but often there is more fighting than feeding.

This kind of chaos could be deadly for young baboons, who are at birth almost as dependent as a human infant. But it is not. The battered-baboon syndrome does not exist.

Baby baboons are equipped with built-in protection against adult aggression. Unlike their all-brown parents, they have pink skin and black hair. These characteristics do more than add a little color to baboon life. They are a hands-off sign to all baboons that allows the youngsters to enjoy safety and relative tranquility in a society where violence is the rule.

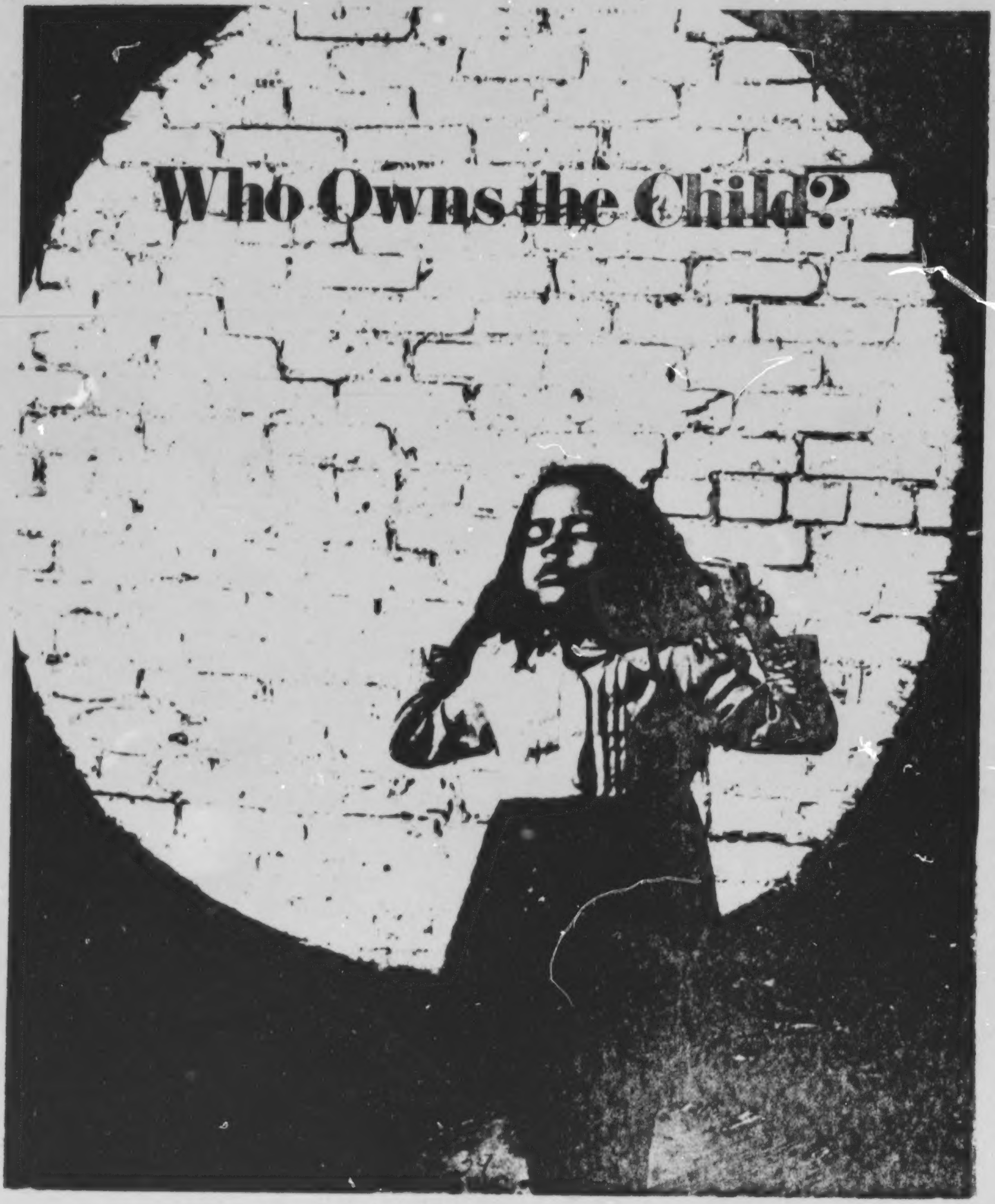
Chimpanzees are not nearly as violent as baboons. In fact, violence seems too strong a word for their infrequent fights. But, just in case, chimp children are equipped with an aggression inhibitor, a tuft of white hair on each little black bottom. These cotton tails render the infants immune to adult aggression and buy a large chunk of tolerance for childlike behaviors. They get away with murder.

Many primate species have this kind of system. Some physical characteristic of the young animal signals, "I'm a baby, don't hurt me." As the animal matures, dependency decreases and so does the signal. It disappears when the individual is mature enough to be part of society, subject to all the regular rules and retributions of proper primate existence.

It would be nice if the romantic myths about how human babies make everyone feel kind and loving were true. Unhappily, both DeMause and common knowledge tell us they are not. *Homo sapiens* are among the very few primates who are unable to keep abusive paws off the defenseless young.

According to DeMause, it looks as if we may be catching up with our more civilized relatives. But just think how much easier it would have been if we had kept some of our beastly characteristics in the first place.

—Joyce Dudney Fleming


Who Owns the Child?

Childhood Education 50 (March 1974)
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An insightful background paper
*on one of the critical social issues of our time.**

Mary Van Stolk, author of The Battered Child in Canada *(Toronto/Montreal: McClelland & Stewart, Ltd., 1972), resides in Montreal. She is currently working on a book about violence in the family.*

Mary Van Stolk

Physical abuse of children is the intentional, non-accidental use of physical force, or intentional, non-accidental acts of omission, on the part of a parent or other caretaker interacting with a child in his care, aimed at hurting, injuring, or destroying that child.[1]

A RECENT CONFERENCE on the battered child, sponsored by the Canadian Department of National Health and Welfare, recognized that at present, in Canada, only a portion of child battering is correctly diagnosed and that, in addition, many children suffer because of failure of family, neighbours, teachers, physicians and others to report. The conferees expressed the belief that reporting, diagnosis and treatment could be improved through education and an interdisciplinary approach to the problem. They emphasized that battering is the discernible tip of a much larger question, and on that basis advised the government that child battering should be recognized as but part of the serious overall problem of abused children in Canada.[2]

THE ROOTS OF ABUSE

Diagnosed physical injuries to children are the visible signs of a problem that, in its hidden forms (neglect, abandonment, emotional abuse), can be equally serious and costly to the child, the family and the society. One hidden portion of child abuse was pointed out recently by Dr. Karl Evang, Director-General of Health Services of Norway, who reported to the World Health Organization that an increasing number of Scandinavian children have been wrongly diagnosed as mentally retarded when their condition was actually the result of deprivation of love.[3] Undiagnosed brain damage is another part of the hidden problem of child abuse. The number of children who suffer brain damage as a result of battering can be statistically tallied, but the number who suffer brain damage as a result of physical abuse that is never diagnosed is probably much higher.[4,5]

Identifying the Abused

Identification of incidences of child battering usually rests on a diagnosis of the injuries, which most frequently are broken bones, single and compound fractures, concussions and skull fractures, internal injuries, bruises, multiple welts, swelling, split lips, blackened eyes, lost teeth and burns.

Sometimes only one child is singled out as the recipient of these crippling, maiming or lethal assaults. However, all the children in

* Adapted from a presentation to the American Orthopsychiatric Association at its Fiftieth Annual Meeting, held in New York City (May 1973). By permission of the Association.

these families are witnesses to the actions, and hence grow up with abuse as the dominant childrearing method taught in the home. The abused and battered child and the abusing parent are thus locked in a cycle of destruction, which too often renews itself in each succeeding generation.[6]

Most deaths occur under the age of five. However, the prognosis for battered children, even when they are removed from the home, is not good. A study reported to the American Academy of Paediatrics, by Gregg and Elmer, points out that of those children who suffered multiple skeletal trauma inflicted by abusive parents early in life, only about 10 percent fully recovered. The remaining 90 percent are still marked by physical, mental and emotional scars as they approach adolescence. Few of the children studied gave promise of becoming self-sufficient adults.[7]

The Nature of Abusers

Information on abusing parents has primarily centered around those who have severely injured their children in a physical sense; and studies of their backgrounds indicate that abuse is cyclic, in that these parents seemed to be carrying out the kind of violent childrearing methodology they themselves experienced at the hands of their own mothers and fathers.[8] Because abusing parents have almost always suffered brutalization in some form, failure to recognize *all factors* of abuse as harmful may not succeed in protecting the next generation.

Boisvert suggests a typology to give researchers and others some concept as to what kinds of personalities batter children.[9] His first classification is the *psychotic* personality. Perhaps 10 percent of battering parents are psychotic and, in these cases, abuse is always unpredictable and uncontrollable. Second, the ***inadequate*** personality, where the abuser is immature, irresponsible and impulsive, and has a very low tolerance for frustration. Third, the ***passive-aggressive*** personality, where the abuser shows hostility and anger at having to meet expectations of others. Fourth, the ***sadistic*** personality, where the abusive parent has a history of sadistic behaviour, usually including frequent beatings or even killing of animals. Finally, the *controllable abuser*, where abuse is a result of displaced aggression and the locus of the problem is usually a marital conflict.

Whatever their pattern of personality disorder, these people give adult confirmation of Gregg and Elmer's study of children who were mistreated and who evidence, in adolescence, inability to recover to the stage where they could be expected to be self-sufficient adults.[10]

The Importance of Modeling

Researchers, such as Helfer and Kempe, Steele and Pollock, point out that nurturing is learned, and that the inability of battering parents to mother or father, hence nurture children, comes from the lack of nurturing these parents experienced in their own childhood.[11] As children, battering adults did not receive the kind of nurturing they needed in order to become parents who in turn have the capacity to nurture. Rather, what they learned was a methodology which taught how not to mother or father, how not to protect and, in fact, to often feel great anger and resentment toward a child who makes a plea for nurturing.[12]

Studies on modeling and aggression, by Bandura, Walters and others, support the concept of modeling in the family as the dominant factor upon which all other learning rests.[13, 14] This concept is based on the assumption that the primary process of family education and learning is that of example: the getting or giving of information is a secondary process. Children learn to walk because they see others walk, to talk because they hear others speak, not because they are taught to walk or speak. The child mimics and models his speech patterns after the adults around him. The child also models his behaviour, emotional responses, cues to laughter, tears, rejection, fears, hostilities, pleasures or compassion, and imitates the adults and children he sees.[15]

In the area of child abuse, the most important factor is what the child sees, hears, feels and experiences in his home environment. That is, child abusers are created by exposing children to the model of abuse. Good parents are made by exposing children to the model of good parents.

The ability to nurture is part of the earliest, hence primary, learning process. Not surprisingly, therefore, studies of cultures where the parental model is nurturing show little or no child abuse. Nurturing cultures hold philosophical and religious beliefs about the rights and privileges of children that create and support the parental desire to fulfill the needs of the child. In these cultures it is considered shameful to strike a child, or inappropriate to treat children as anything other than welcomed guests in one's house.[16,17]

ANTHROPOLOGICAL AND HISTORICAL PERSPECTIVES

The work of anthropologists such as Jules Henry and others documents that North America is a punitive childrearing culture.[18,19] Cultural beliefs and traditions about the rights of children play a large role in maintaining attitudes toward family life and the position of the child in the North American home. Delsordo wrote in 1963, "To undertake a study of the entire problem of abused children is obviously bigger than any one profession. Satisfactory results may be obtained only through joint professional endeavour."[20]

It is increasingly important that professionals heed the words of Delsordo, and introduce into the study of child abuse not only the anthropologist and his study of cultures that are nurturing of children, but also the historian to shed light on our own historical beliefs and concepts regarding the rights and ownership of the child.

Children as Property

In *The History of Western Philosophy*, Bertrand Russell outlines the philosophical and historical foundation of our attitude towards parental rights: "Aristotle's opinions on moral questions are always such as were conventional in his day. On some points they differ from those of our time, chiefly where some form of aristocracy comes in. We think that human beings, at least in ethical theory, all have equal rights, and that justice involves equality. Aristotle thinks that justice involves, not equality, but right proportion, which is only a 'sometimes' equality.

"The justice of a master or a father is a different thing from that of a citizen, *for a son or slave is property, and there can be no injustice to one's own property.*"[21]

The Patria Potestas endowed the Roman father with the privilege to sell, abandon, devour, kill, offer in sacrifice, or otherwise dispose of his offspring. Even in adulthood, when the children were in the father's house, they could be sold into bondage, tortured or killed. "In the Forum, the Senate or the camp, the adult son of a Roman citizen enjoyed the pub-

Courtesy of Future Homemakers of America

lic and private rights of a person; in his father's house he was a mere thing, confounded by the laws with the movables, the cattle and the slaves, whom the capricious master might alienate or destroy without being responsible to any earthly tribunal."[22]

The belief that there can be no injustice to one's own property still allows and sanctions the abuse of children under the guise of punishment. Today, society says that a man or woman who strikes a child is committing an assault if the child is not their own, but rarely interferes in the assault of a child carried out as punishment by a parent.

Parental "Rights"

Another link between societal attitude and the battering or abusive parent is confirmed by the lack of protection for the battered child by family members. A large portion of battering incidents occur with the knowledge of family members who have been aware of the abusive treatment of the child, often over a long period of time.[23] Their failure to protect the child supports the theory that, at least in part, members of the family defer to the treatment of the child out of cultural confusion over parental rights.

In North America, another dominant factor in childrearing practices is a belief in the need and parental right to use a high degree of force to punish disobedience. "It is unfortunate what my wife does, but she is the mother." "My husband may be a bit too strict, but he is the father and we don't want spoiled children." These comments are from parents who stood by, aware of the most terrible injuries being inflicted on the child.

Society's overall tendency to insist upon the maintenance of discipline, attendance to rules and obedience from children at all costs is mirrored by the removal of corporal punishment from prisons and correctional institutions, but not from the schools, and is legally upheld in Section 43 of the Canadian Criminal Code, which states that:

> Every school teacher, parent or person standing in the place of a parent is justified in *using force* by way of correction towards a pupil or child, as the case may be, who is under his care, if the force does not exceed what is reasonable under the circumstances.[24]

and in the United States, in states such as Massachusetts, where

> The Massachusetts Supreme Judicial Court has laid down the law for children who talk back and refuse to obey their parents.
>
> The state's highest court, upholding a 317-year-old law, declared unanimously on June 7th, 1971, that children "have no right of dissent" when it comes to obeying the reasonable and lawful commands of parents. The law also applies to children under the supervision of adults other than parents. Known as the "Stubborn-Child Law," it was originated in 1654 because too many Colonial-era children were behaving disrespectfully, disobediently and disorderly toward parents and guardians.
>
> The law was recently challenged as unconstitutional by attorneys for a 17-year-old girl in a home for wayward children at Fall River.
>
> In upholding the law, the court found the girl guilty of being stubborn. She was placed on probation in custody of the Youth Service Board.[25]

The Sanction of Rules

A large segment of North American society apparently still believes in the need to abuse and terrorize children, and is firmly convinced that all manner of paddles, belts, wooden spoons, fly swatters and electric cords are permissible standard equipment for the job. These forms of abuse are often interspersed with threats of one kind or another. "You will be taken to the police station if you are not good." "The boogy man will get you." "You will be put in the cellar, in the alley, in the closet." Terror and solitary confinement, as well as physical abuse, are used to break the spirit and to ensure obedience. These routine, culturally-sanctioned punishments, spankings, slaps, shakings, screaming sessions and threats are not legally classified as child abuse. Often, however, the only difference between the battering home and the so-called normal home, whether

—*New York Times*

it be rich or poor, is the degree of physical or emotional abuse used to enforce rules.[26]

Gil, in *Violence Against Children*, points out that lack of vacations, of play schools, of babysitters and the stress of economic need all contribute to a higher level of general child abuse within the lower income groups. The poor and underprivileged do not have the money to relieve the pressures of childrearing that the rich do.[27] That fact does not mean that abusive parents, whether rich or poor, do not "love" their children. They do. They want, as their parents wanted from them, love in the form of obedience, conformity and respect. Abusive parents love in that they want the best manners, the best marks, the best behaviour from their children. They want their children to grow up to be perfect, and hence a credit to them. They love their children as they were taught to love by their parents.

To the battering and abusive parent alike the rules are all important, and the child is seen in relation to the rules. How does the child live up to the standard of the rules? Is the child's attitude one of submission to the rules? Differences over the kinds and number of rules and levels of attendance and obedience to rules cause one parent to beat or punish a child if one set of rules are broken, while another only beats or punishes to enforce a different set of rules.[28] The battering parent simply takes North American "normal childrearing practices" to the furthest point.[29]

Because of the warped belief in the need for absolute obedience, many deaths and permanent injuries occur. "He would not stop wetting his bed so we had to beat him," goes the rationale. "She would not stop crying so I threw her across the room to show her I meant business." "I told him not to touch the stove but he would not obey, so I took his hand and held it over the burner. Next time I say don't touch, he'll obey."

CHALLENGES TO ABUSE

The Child as Animal

Although today the state attempts to protect the child who is grossly assaulted, only a short time ago the state gave parents the right to beat children without any interference at all. One of the first legal challenges in North America to the absolute rights of parents over children occurred in New York City in 1870. While visiting a tenement house, a church worker learned that a child was being beaten daily by her parents, and that the child was also seriously malnourished and neglected. After appeals to protective agencies including the police and the district attorney's office proved useless, the church worker appealed to the American Society for the Prevention of Cruelty to Animals. In the courts it was pointed out that this child was being treated as an animal and was certainly a member of the animal kingdom. On this basis the Society for the Prevention of Cruelty to Animals won the action, which resulted in the child's removal from her parents.[30] One year later, in 1871, the New York Society for the Prevention of Cruelty to Children was organized. Pathetic is the historical comment that the persistence and tenacity of an unnamed church worker and the S.P.C.A. were required to instigate action in one of the first recorded cases of a battered child.[31]

Why Society Fails To Protect

The sad reality of society's failure to protect children is that a child who grows up in a battering or abusive household runs a high risk of growing up to batter or abuse in turn.[32] The link between an abusing university professor with an IQ of 150 and an abusing mother with a grade six education and an IQ of 100 lies in the physical and emotional brutalization they experienced in their childhood. Abuse, therefore, occurs in all walks of life and in all combinations of social and religious backgrounds.

Failure to protect a child who has once been severely battered means exposing that child to a high risk of death or permanent injury.[33]

Yet society has consistently failed to protect the child, a fact evidenced by the poor reporting rates of child abuse both in the United States and Canada, not only on the part of family, neighbours and teachers, but more alarmingly on the part of physicians and other medical personnel.[34]

In examining the reasons why society has failed to protect the child, it becomes apparent that there is more than just a reluctance to become involved, but rather an unwillingness to break an old and cherished belief with regard to the rights of parents over children. North American society has yet to recognize that the child is not the property of the parents, but a citizen in his own right.[35] This concept of parental ownership is mirrored by physicians who fail to report a battered child out of loyalty to the physician-patient privilege; that is the belief that the parent is his patient and hence to be protected, rather than the child.

Need for Preventive Action

The wisest protection is that which not only protects but prevents. Care for the child and the parent is essential, but before help can be offered, the diagnosis of child abuse must be made. Ever since the Battered Child Syndrome was first recognized, it has been apparent that the major protection for the child could only come through early diagnosis and treatment, which hinge directly on the physician's reporting and his willingness to support his diagnosis by medical testimony in court.[36]

Each discipline has a vital role to play in the protection of the child. Society, represented by family members, neighbours, teachers, nurses, physicians and others, must report to a protective agency all suspected cases of abuse. Social agencies must investigate these reports with a high degree of skill and competence, and seek diagnosis from medical practitioners who understand the diagnostic techniques available to them in assessing the extent of injury sustained by the child. Lawyers and magistrates must then appraise this information, not from the position of parental rights, but from the primary concept that a safe environment is the legal right of all children, and on that basis decide the relative safety or lack of safety of the child's environment. If at any point one discipline fails to maintain its responsibility in the chain of events from the original report to final legal assessment, the opportunity to protect the child and help the parents may be lost.

SUMMARY

In summary, child battering appears to be a symptom of a major problem, child abuse. No matter what emotional or personality disorders abusers exhibit, they are evidencing an adult response to their own abusive childhood experience.

The ability or lack of ability to nurture is learned; the child models his behaviour after the parents or other dominant models. Nurturing parents produce children who grow up with an ability to nurture. Violence breeds violence.

Child abuse is an interdisciplinary problem. Anthropologists point out that North American childrearing practices are punitive, and give evidence of other cultures that recognize the needs and rights of children. History exposes the basis of our concept of the ownership of children, and the belief that one can do what one wants to one's own child.

Western society is still mirroring cultural beliefs of the past, as evidenced by its reluctance to interfere with the ownership rights of parents, even when the child's human rights are obviously being violated.

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I. THE PHENOMENON OF CHILD MALTREATMENT

QUESTIONS AND ANSWERS ABOUT CHILD MALTREATMENT (I.4)

1. Is child maltreatment increasing?

That's hard to say. Some authorities feel that due to publicity the problem is just more visible now than it used to be. Others say that today's economic and social conditions are promoting increased maltreatment. A statistical clearinghouse has been established to collect data about child maltreatment across the country. Thus, in the future we'll have more accurate means of comparison.

2. What national statistics do we have now?

A sampling study conducted by the Mershon Center at Ohio State University estimates that approximately 600,000 cases of child abuse and neglect were substantiated. This report estimates that another 325,000 incidents occurred but were not reported.

A projection based on data from state central registries (registries whose accuracy varies greatly) indicates that there were over 41,000 cases of confirmed physical abuse alone in 1973. Most experts agree, however, that the true incidence rate may never be known since the number of reported cases represents only a fraction of the number of cases which actually occur.

3. How many deaths from maltreatment occur annually?

Recent studies indicate that as many as 2,000 children die each year in circumstances when maltreatment is suspected.

4. How does this compare to other childhood diseases or death statistics?

2,961 children between 1 and 15 years of age died of cancer in 1973. During that same year, 1,345 died of influenza or pneumonia and 680 of heart disease. The leading cause of death in children was accidents, which claimed 12,486 lives.

5. Are there more abuse than neglect cases?

No. Neglect seems to occur three to six times more frequently, according to studies.

6. Who abuses more frequently, men or women?

The percentage is about even.

7. What about neglect?

Neglectful caretakers may be either sex.

8. Is any age group more apt to maltreat than any other?

No. Maltreatment is found among all age groups. However, there is evidence that maltreatment by young caretakers may be on the rise. If this is so, the rise may be related to the stresses of financial insecurity, immaturity, and marital instability often found among this age group.

9. Is any educational level typical of the maltreating caretaker?

No. Maltreating caretakers may be college graduates or may never have completed elementary school, with all educational levels in between represented.

10. Is there any typical economic level?

No. Maltreating caretakers may be rich, poor, or in between. They may be professionals or unemployed. However, those in lower socio-economic levels may be more visible because they tend to use public facilities.

11. Can any ethnic group be called typical?

No. Maltreating caretakers come from every ethnic background. Neither do they represent any particular religious group. In short, those who maltreat are representative of a cross-section of the American population.

12. Who are maltreated more frequently, boys or girls?

Overall, the numbers of maltreated boys and girls are about even. Some studies have indicated that infant abuse occurs slightly more often among boys, while adolescent abuse occurs slightly more often among girls.

13. What is the average age of the maltreated child.

The maltreated child may be any age. About half of them are under five. The other half are of school age, with a growing number of them adolescents. Statistical data now being collected by the government should soon give us a more definitive age profile of the maltreated child.

14. Is the maltreated child more likely to live in an urban area or a rural area?

The maltreated child is found everywhere -- inner city, suburb, and rural areas. The conditions which give rise to maltreatment cannot be said to be restricted either geographically or sociologically.

15. What are the kinds of abuse and neglect?

Abuse and neglect may be physical or psychological. Physical acts of abuse and neglect include burning; beating; and failing to provide adequate food, clothing, or shelter. Psychological acts of abuse and neglect include berating, threatening, and witholding love.

16. Is spanking maltreatment?

Usually not, though under certain circumstances it can be. For example, spanking a two-week-old infant is considered maltreatment. A "spanking" which results in broken bones is also considered maltreatment.

17. Is anything being done to reduce the incidence of child maltreatment?

Yes. In 1974, the Child Abuse Prevention and Treatment Act focussed national attention on prevention of child maltreatment and provided funds to begin preventive programs across the country.

Since the passage of this federal act, there has been a great deal of research into the causes of child maltreatment as well as the effects of child maltreatment on both the individual and society. Despite these efforts, however, much more remains to be done at the community level. (See Units V. and VI.)

Child Abuse and Neglect Programs: *A National Overview*

by Saad Z. Nagi

In the wake of rising public concern over the abuse and neglect of children, concern that culminated in the passage of the Child Abuse Prevention and Treatment Act, a study to survey current programs in the field was undertaken early in 1974. The study was planned to gain a general overview of programs in the United States, to identify gaps in the design and problems in the performance of these programs, and to identify needs and directions for new program development.

Reported here are some of the highlights of the findings from our initial phase of analysis, together with a brief review of our approach to the study, which was supported by a grant from the Office of Child Development. The study is being conducted by the Mershon Center, Ohio State University.

Approaches

The study plan was organized around two complementary aspects. The first comprised intensive interviews with judges, physicians, caseworkers, policemen and others in a number of communities selected on the basis of variability, in order to gain an understanding of the issues, problems, weaknesses and strengths of programs in the field. Interviews in selected programs will continue until a final report is completed.

The second aspect of the research is based on a survey of agencies and programs involved in abuse and neglect. This represents a probability sample of the United States population and includes all of the official agencies in 129 counties that are actually providing service to one-third of the total U.S. population (excluding Hawaii and Alaska). Seven types of agencies and groups of respondents were included in this survey, with data collected through personal interviews.

The agencies, the persons interviewed, and the number of interviews completed, include:

- Child Protective Services (directors or most knowledgeable member of staff, 129)
- Juvenile and Family Courts (judges or court referees, 134)
- Police and Sheriff Departments (heads of juvenile division, 288)
- Public Health Departments (supervisors of maternal and child nursing services or directors of nursing services, 148)
- School Systems (assistant superintendents for pupil personnel or persons in equivalent positions, 330)
- Hospital Medical Personnel (pediatricians who headed or participated on hospital teams or special programs on abuse and neglect or the pediatricians most knowledgeable in this area, and chiefs of staffs in hospitals where no pediatricians were available, 350)
- Hospital Social Services Departments (heads of departments or most knowledgeable members, 317).

In all instances we were careful to specify that the most knowledgeable administrative person be interviewed.

A total of 1,969 interviews were completed, representing about 97 percent of the respondents sought in the survey. The highest completion rates —99 percent—were for child protective agencies, police departments and public health departments. The lowest —90 percent—was for physicians.[1]

Agencies were asked about the number of cases of abuse and neglect that were referred or reported to them during the year prior to the survey (1972-73). In computing rates of reporting, the numbers of children under age 18 presented in the 1970 U.S. Census are used as a basis.[2] Of the 129 counties served by the child protective agencies in the sample, 116 provided information on the levels of abuse and neglect reporting. (The other 13 were assigned the average rate of reporting in those

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CHILDREN TODAY May June 1975

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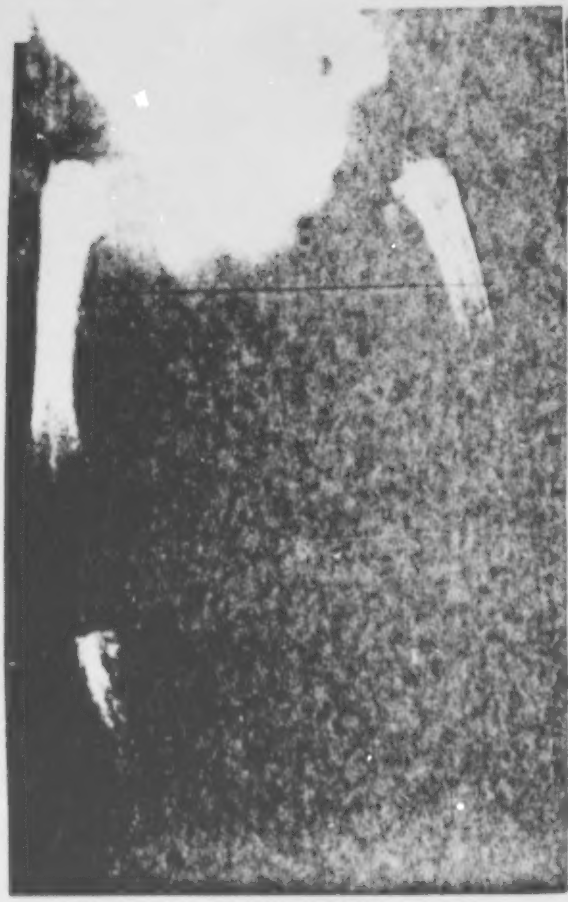
for which data were available.)

The rate of reporting in all of the counties was 7.6 per 1,000. That is, for nearly 24 million persons 17 years of age and younger living in these counties, slightly over 180,000 cases were reported to the county agency.[8]

When these rates of reporting were weighted according to the population areas represented, we have a corrected reporting rate of 8.8 cases per 1,000 children. Thus, for the 69 million children below 18 years of age estimated to reside in the U.S. in 1972, it can be expected that about 600,000 reports of child abuse and neglect came to the attention of local protective agencies during that year. The proportions of reports which were substantiated have not yet been analyzed, nor did the agencies specify the numbers forwarded to central registries in their states. It is also important to keep in mind that abuse and neglect statutes vary among the states as to definitions, ages of children and criteria for mandatory reporting, all of which will influence the volume of cases reported to central registries.[9]

The State of Florida is considered to have the most effective reporting system. Statewide WATS lines backed by an effective public information campaign and changes in the laws have resulted in a dramatic increase in the number of cases reported throughout the state. From the beginning of October 1972 through September 1973, a period that most closely coincides with that covered in this survey, 29,013 children under 17 years of age were reported in Florid as victims of abuse and neglect. Whil the Florida statutes define the age o reportable children as 16 or younger data sought in this study were base on ages 17 and younger. Correctin for this age difference, we estimat that 30,128 cases would have bee reported in Florida during that year a reporting rate of about 13.4 pe thousand children. Projecting th rate to the slightly more than 69 million children in the nation would yiel about 925,000 reportable cases. Considering that nearly 600,000 cases ar estimated to have been reported, it ca be concluded that about 325,00 abused and neglected children wer *not* brought to the attention of protective services during that year.

Of all the reports made in Florida,



(1) Parents of this 7-month-old boy said he "fell out of the high chair," yet doctors found lesions depicting some kind of instrument on his face, and a right parietal skull fracture. (2) This 3-year-old child, who weighed 17 pounds at hospitalization suffered from severe malnutrition and skin abrasions. Within [illegible] days he gained 10 pounds. (3) Examples of cigarette burns inflicted by parents as punishment. (4) Wringer injuries inflicted by adults who repeatedly pull and twist a child's extremities are identifiable by X-ray. The hazy areas around the joints are calcium deposits. (5) One of two sisters brought to the hospital because of severe beating. Some of the lesions on her back are old, some new. (6) An X-ray examination of this 7½-month-old boy, brought to the hospital with fractures, rickets and other signs of abuse, disclosed the straight pin which was inserted into the uretha with the head of the pin in the bladder. (Photos: Medcom, Inc.) (7) This little boy, about five months old, was operated on to remove a blood clot caused by his being beaten or thrown. He suffered severe brain damage and died in the hospital a few months later. (Photo: Children's Hospital National Medical Center, Washington, D. C.)

about 60 percent were subsequently substantiated as entailing abuse and/or neglect. If this rate is projected to the national population, there would be about 555,000 cases of substantiated abuse and/or neglect annually. Estimating that about 60 percent of these, or approximately 360,000 substantiated cases, were reported to child protective agencies, there would be about 195,000 cases which could be substantiated that were not brought to the attention of agencies.

It should be pointed out that the rates of reporting in the 129 counties represented by the protective agencies included in this survey ranged from a low of .25 per 1,000 children to a high of 59.62 per 1,000, and that reporting rates in 20 of these counties were higher than those of the State of Florida. One might interpret this to be an indication of under-reporting in Florida or of variability in the incidence rates of abuse and neglect in different parts of the nation.

All of the above figures include both abuse and neglect. Although differentiation between them may be difficult at times, we asked respondents from protective services about the proportion considered to be abuse. The weighted average for the total sample was 27.9 percent. Using this proportion, we estimate that about 167,500 cases of abuse were reported. *If* the nation's level of reporting were the same as that of Florida, it might be concluded that nearly 91,000 more abused children were not reported.

These estimates may be compared, in the table (page 16), with two other recent and careful efforts.

As can be seen, our estimates—based on a national sample of *reporting to local agencies*—are more in lin with data from the national survey while those based on *actual* reportin to state central registries indicate much more limited incidence, or wh is possibly an unwillingness to repo any but "serious" cases to the centr registries.[8]

Reporting Agencies ●

Agencies representing 58 percen of the population served indicated tha hotlines existed in their area, some of which were shared for other types of emergencies. Among sources of reports to protective agencies, police departments seem to have been most consistent and private physicians the least. Protective agencies representing three-quarters of the population served maintained that they "always" or "often" received reports from police departments, but agencies representing only about one-quarter mentioned similarly high levels of reporting for private physicians. Next to the police, the second highest reporting was from public health departments, followed by hospitals, with schools being the lowest in levels of reporting. Reasons given by protective services for non-reporting on the part of other agencies include lack of knowledge about reporting requirements, lack of resources and manpower, red tape and lack of confidence in protective services. Many of these agencies (police, public health and the schools) also preferred to deal with the cases themselves, notwithstanding mandated reporting. Non-reporting on the part of private physicians was largely attributed to "not wanting to get involved" and to the role conflicts inherent in reporting a patient for punitive action.

Temporary Placement

Several questions were asked about the type of facilities used for temporary placement of children, the problems encountered and the quality of available facilities. Reports from protective services indicate that the great majority of children are placed in foster homes. Placement with relatives was the second most frequently used resource. Agencies representing slightly less than one-quarter of the population also mentioned the use of detention homes.

Problems in placement were reported by agencies representing 56 percent of the population. The most frequently mentioned problem was the limited availability of foster homes or other facilities; the poor quality of those available was the second. The intensive interviews conducted in a number of communities highlighted the difficulties in temporary placement, a major issue in serving abused and neglected children.

Decision Making

The identification and management of child abuse and neglect cases entail many important decisions by human service and law enforcement personnel. Decisions to report suspected abusers, to remove children from their homes, to place children in certain facilities and to recommend severance of parental rights are very serious.

Caseworkers make decisions on temporary removal of children in agencies representing about 60 percent of the population and on permanent separation in agencies representing 42 percent. In police departments representing over 60 percent of the population served, the officer on the scene makes decisions on removal. The criteria upon which such decisions are based are diffuse and subjective.

We have additional evidence of uncertainty regarding decision making throughout the system. Respondents from protective agencies representing 56 percent of the population served and from police departments representing 64 percent agreed that "It is difficult to say what is and what is not child mistreatment." Higher proportions of judges and physicians indicated similar uncertainty. There were even greater rates of agreement with the statement, "It is difficult to determine when parents should have their children returned." Proportions of the population served by agencies in agreement ranged from 64 percent for the courts to 84 percent for hospital medical personnel.

Available literature indicates that where criteria for decisions are unclear, many extraneous factors may have considerable influence on decisions. Respondents for each of the agencies were asked how much members of their respective agencies vary in decisions and approaches to problems of abuse and neglect. As we might expect, "great" variations were reported among caseworkers in protective services (20 percent) and hospital medical personnel (75 percent). "Some" variations were reported within agencies representing much larger proportions of the population.

Interagency Coordination

Depending upon the reporting agency, 56 to 75 percent of the population lived in areas where there were no centers on child abuse and neglect, no interagency teams, and no liaison committees or other interagency coordinative mechanisms. The prevalence of centers, teams and liaison groups was associated with the volume of cases of abuse and neglect reported.

Table I

Mershon Center Estimate

	Reportable	Reported	Not Reported
Abuse & Neglect	925,000	600,000	325,000
Substantiated		360,000	195,000
Abuse Only		167,500	91,000

Cohen & Sussman Estimate*

Confirmed Abuse, 1973	41,104

Light Estimate**

Abuse Only	200,000 to 500,000
Abuse & Neglect	465,000 to 1,175,000

* This estimate, based on actual reporting in the 10 most populous states and projected to the national population, is reported in Cohen, Stephan J. and Sussman, Alan, "The Incidence of Child Abuse in the United States," unpublished report submitted to OCD, 1975.

** These estimates are based on data compiled by David Gil from a National Opinion Research Corporation survey conducted in 1968. See Light, Richard J., "Abused and Neglected Children in America: A Study of Alternative Policies," *Harvard Educational Review*, November 1973.

Coordinating bodies varied in composition, functions and administrative location. Most commonly, department heads and supervisors participated in coordinating efforts, which may indicate that the major function for the majority of coordinative mechanisms is interagency relations rather than actual case management. Emphasis upon the latter would require the participation of policemen, caseworkers, nurses and others directly engaged in the delivery of services. Teams and liaison groups usually met once a month, which also indicates agency coordination, not case management.

The lack of coordination is reflected in responses to a number of other questions. One question, for instance, sought to discover whether the ways other agencies handle cases of child abuse and neglect delay or cause problems to the respondent's own agency. The proportion of population represented by protective agencies encountering difficulties ranged from 29 percent for prosecuting attorneys offices to 57 percent for the schools.

Another question asked: "Considering the various facets of child abuse and neglect and the many agencies involved, what problems do you see in the way child abuse and neglect is handled in this area?" Here the most frequently mentioned problem was limitations in interagency cooperation.

Agencies' Performance

In many respects, the foregoing discussion indicates the levels of performance of programs addressed to the problems of abuse and neglect. The volume of cases identified and reported, the status of interagency coordination, the prevalence and nature of problems encountered by each of the agencies because of the ways other agencies handle abuse and neglect cases, and the nature of the criteria and structure for decision making all constitute important indicators of program performance. The survey also included other approaches to assessing performance that require more complex analysis than could be completed for the purposes of this initial report. However, responses to some direct questions are instructive.

We discovered, for example, that child protective agencies representing 50 percent of the population do not necessarily make home visits during the same day cases of child *abuse* are reported. The equivalent proportion for child *neglect* is 82 percent. On the other hand, police departments representing 96 percent of the population conduct a home visit during the same day for cases they consider to be emergencies, and 78 percent for other cases. When asked about the proportion of families that continue to abuse their children after protective services have become involved with them, respondents for agencies representing only one-third of the population answered "almost none" while respondents representing 14 percent of the population indicated a belief that one-half or more of the families continue abusing their children after protective services become involved.

Opinions were also sought concerning the effectiveness of programs. For example, respondents were asked to react to the statement, "Treatment for parents who mistreat their children is largely ineffectual." Agencies that agreed with this statement ranged from public health and protective services (representing 28 percent of the population) to the police and sheriff departments (representing 48 percent). When asked to evaluate the effectiveness of their own agencies, the police were most optimistic and public health departments most pessimistic. Similarly, the police were most generous in their assessment of the effectiveness of other agencies in the community, and the courts next. Public health departments continued to be the most pessimistic.

Many reasons for the lack of effectiveness were attributed in responses to questions seeking information about the availability of services and resources, priorities for program development should additional funds become available, and the nature of problems encountered by the respective agencies in handling the problem.

The proportion of the population ranged from 38 percent for schools to 85 percent for protective agencies that answered the following question affirmatively: "Are there any services that abused and neglected children or their families need that are unavailable or difficult to obtain?"

Counselling was the service mos often mentioned as lacking by r spondents from all agencies. The nee for home support, placement facil ties and financial support were als frequently indicated. Problems in in teragency coordination and inad quacies in manpower and staff qual fications have already been pointed ou as two major impediments to progra effectiveness.

It is premature to attempt to dra conclusions during this initial stag of analysis of such an extensive an complex set of data. Rather, the ob jective was to present some of the im portant trends and to share some o the thoughts they provoked. The fig ures presented and the statemen made are subject to further refineme and qualification as we proceed wit future reports on this study. How ever, I hope that this report has pr vided some overview of programs o child abuse and neglect in this natio

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Sampling and data collection we carried out by the Survey Research Cen ter of the University of Michigan's Inst tute for Social Research. The method ology for this sample is provided in Kish L. and Hess, I., *The Survey Resear Center's National Sampling of Dwellings* Ann Arbor: Institute for Social Re search, University of Michigan, 1969.

All percentage responses are carefull weighted to reflect the proportion o population they serve. Thus, the opin ion of a judge or court worker in metropolitan area is given more weigh than that of a judge in a rural area wh sees only a few cases per year.

U.S. Bureau of the Census, "Genera Social and Economic Characteristics U.S. Summary 1970," June 1972.

Further analysis is needed before at tempting to compare the figures obtaine in this survey with earlier reports suc as are found in Gill, D., *Violence Agains Children*, The Commonwealth Fund 1970 and Light, R., "Abused and Ne glected Children in America: A Study o Alternative Policies," *Harvard Educa tional Review*, November 1973.

See DeFrancis, V. and Lucht, C *Child Abuse Legislation in the 1970* The American Humane Associatio Denver, Colorado, 1974.

Cohen, Stephen J., "A Study o Child Abuse Reporting Practices an Services in Four States," unpublished r port submitted to OCD.

See, for example, Nagi, S., "Gat Keeping Decisions in Service Organiza tions When Validity Fails," *Huma Organization*, Vol. 33, No. 1, Sprin 1974.

I. THE PHENOMENON OF CHILD MALTREATMENT

DYSFUNCTION IN SOCIETY, THE FAMILY, AND THE INDIVIDUAL (I.6)

The phenomenon of child maltreatment is ascribed to be the symptom of a dysfunction within society, the family, or the individual which manifests itself when a child is physically or psychologically damaged.

Suggested Areas of Dysfunction	Suggested Examples of Dysfunction
1. Society	
a) Economic conditions	Poverty
b) Environmental conditions	Racism
c) Social values	Violence
d) Institutions	War
	Moral decline
2. The Family	
a) Intra-familial relationships	Marital problems
b) Child-rearing practices	Child delinquency
c) Family structure	Isolation
d) Life style	Financial problems
	Addiction
3. The individual	
a) Physical incapacity or inability	Sick
b) Mental incapacity or inability	Disabled
c) Psychological (emotional) incapacity or inability	Uninformed
	Retarded
	Psychotic
	Neurotic

(Transparency 1)

Table 1

Mershon Study Center

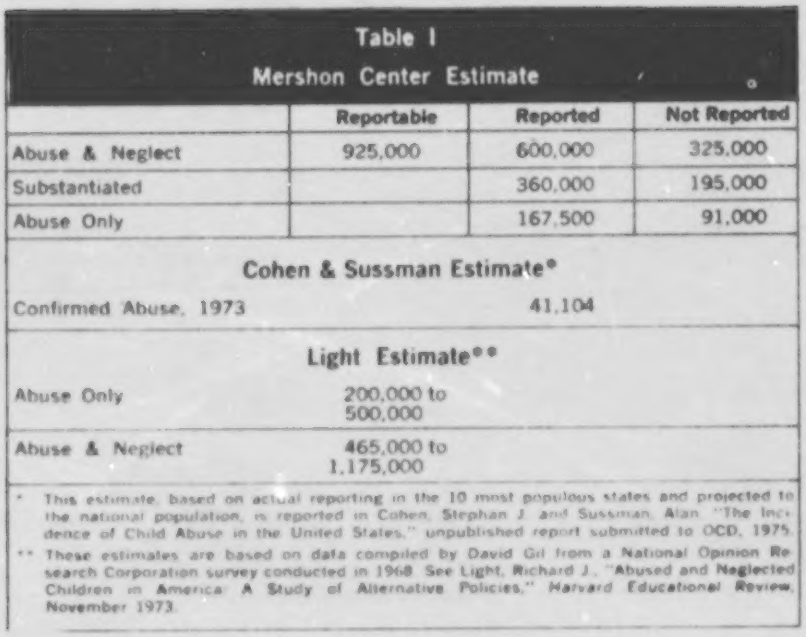

Table I

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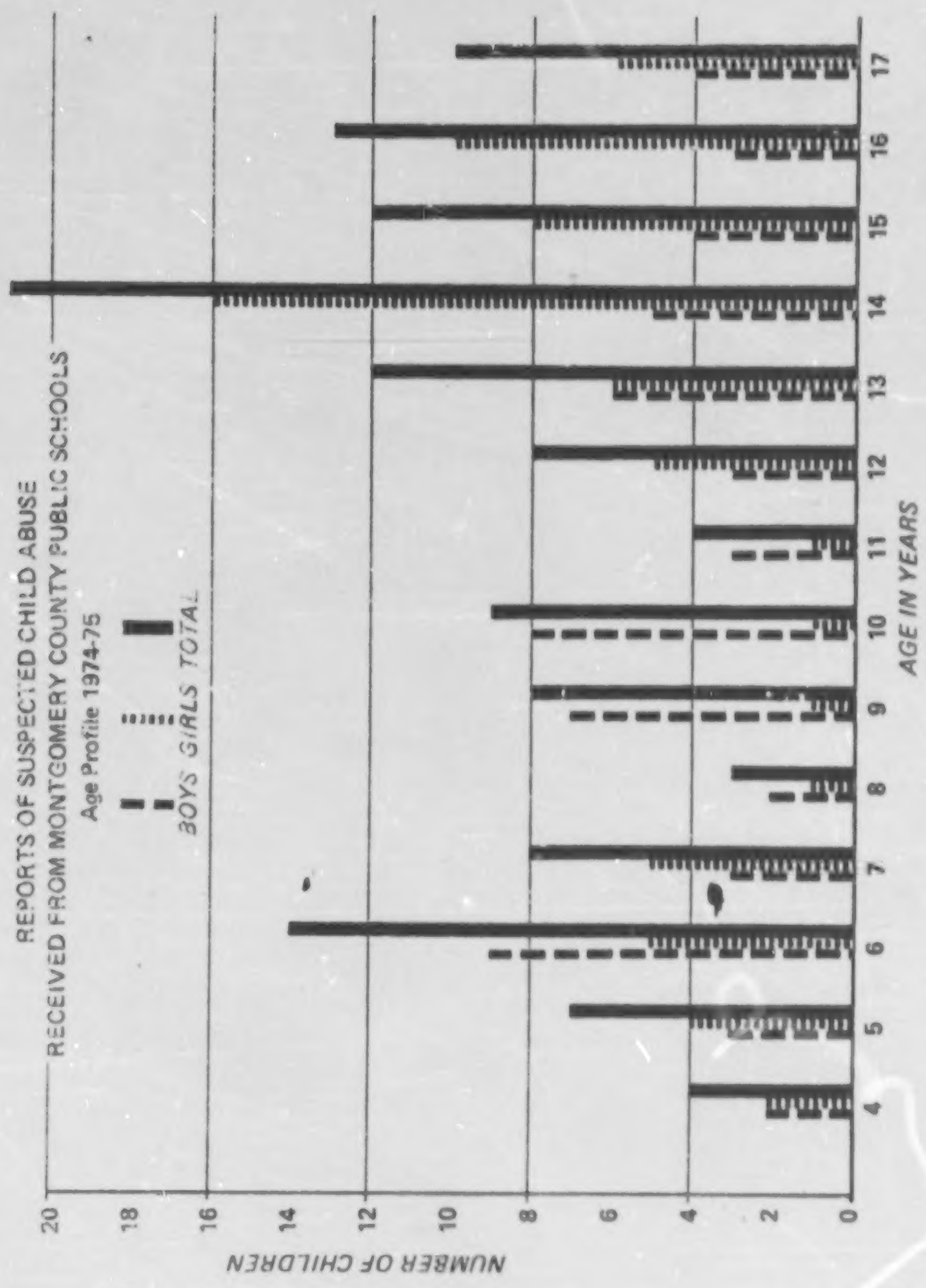
Reprinted from Children Today 4(May-June 1975)

(Transparency 2)

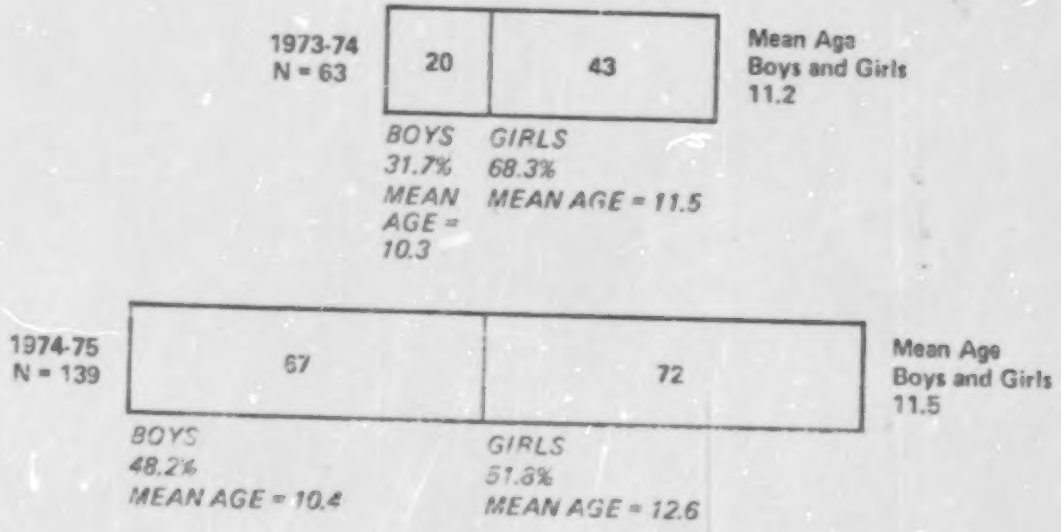


Project PROTECTION
Annual Report September 1975
Montgomery County Public Schools
Rockville, Maryland

Project PROTECTION
Annual Report September 1975
Montgomery County Public Schools
Rockville, Maryland

REPORTS OF SUSPECTED CHILD ABUSE RECEIVED FROM MONTGOMERY COUNTY PUBLIC SCHOOLS

Sex and Mean Age of Children Reported



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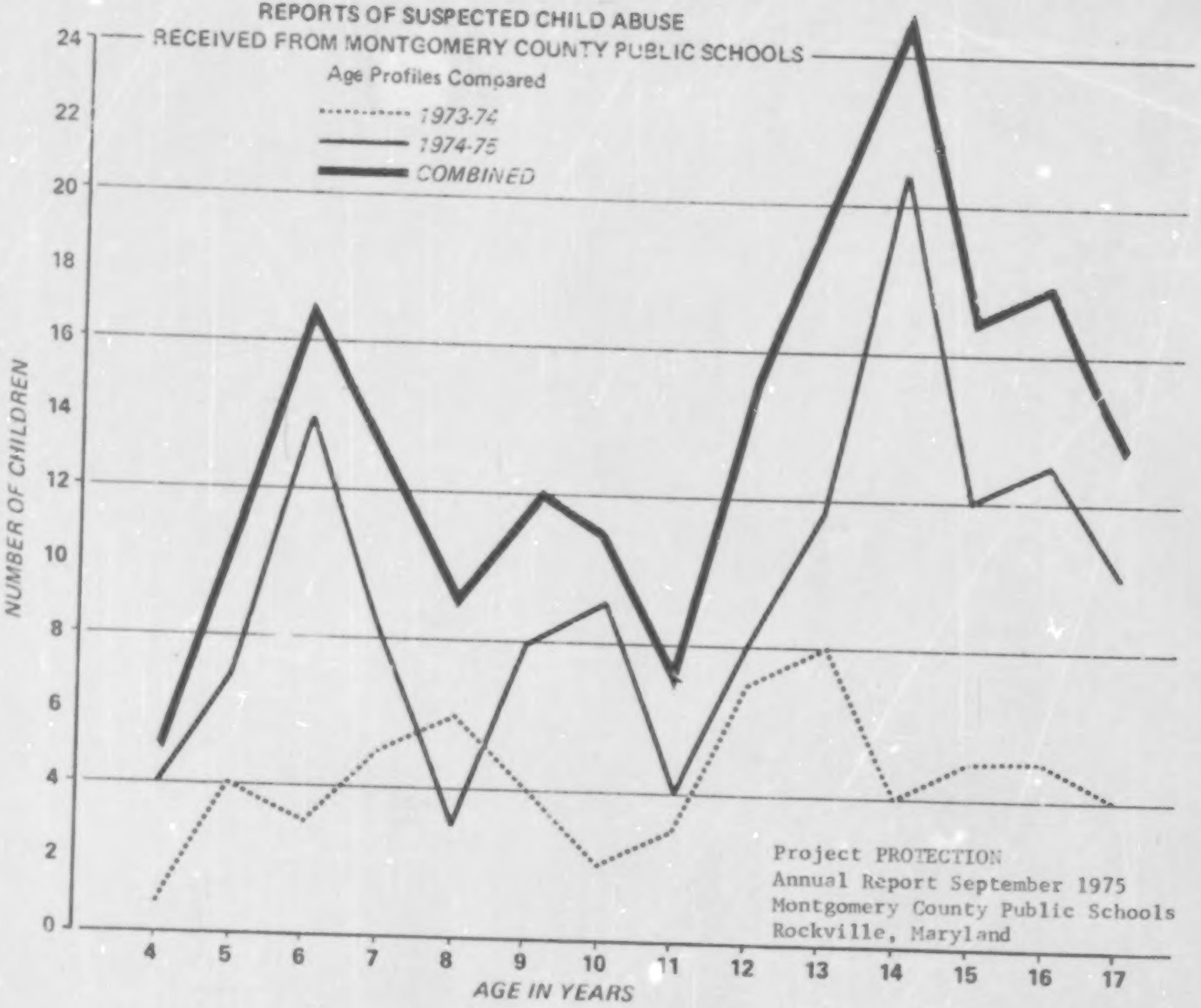
(Transparency 4)



Project PROTECTION
Annual Report September 1975
Montgomery County Public Schools
Rockville, Maryland

A-12 MONTGOMERY COUNTY SENTINEL Thursday, November 7, 1974
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Child abuse reports have increased since 1972

By Roberta Wyper
Sentinel Staff Writer

The Montgomery County Department of Social Services received 477 reports of child abuse and neglect between Jan. 1 and Aug. 31, 1974, according to statistics released last week by the county Child Abuse Task Force.

Schools were the single largest reporting source (24 per cent), followed closely, by private citizens (22 per cent).

The Department of Juvenile Services and the courts reported the least number of cases (3 per cent) followed by hospitals (4 per cent).

In between were the police department's juvenile section. (13 per cent) and relatives (16 per cent).

During the last three years there has been a sharp increase in the number of child abuse cases reported in the county, according to the report. In March of 1974, there were approximately 300 validated cases on the rolls of the Social Services Department, compared to 199 in June 1973 and 47 in June 1972.

The increase in reported cases, the report says, is due mainly to such recent Child Abuse Task Force accomplishments as:

- A 24-hour reporting line with follow up investigations of reports within one hour.
- A public education program using the news media, a speakers bureau and public meetings.
- The passage of state legislation requiring physicians to examine children brought to them by a policeman or social services worker, with or without parental consent, and granting immunity from civil liability and criminal penalty to doctors when parental consent is not obtainable.
- Establishment of a permanent seven-member Child Protection Team consisting of specialists in pediatrics, psychiatry, juvenile investigations and other related fields.
- Appointment of a Child Protection Coordinator -- Leila Whiting -- and a staff in the Office of Human Resources, responsible for coordinating plans for prevention and treatment.
- Initiation of project PROTECTION, a three-part program within the Montgomery County public school system designed to educate students and staff on the child abuse problem.

In addition, the study says, the task force has been working closely with county schools, hospitals, Juvenile Court and the county Health, Police and Social Services departments.

The Montgomery County Task Force on Child Abuse was established by the county executive in November 1972, to develop programs and aid in the treatment of children who are abused and neglected.

By Kenneth Keniston

Yale Alumni Magazine 37(1974)
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'Good Children' (Our Own), 'Bad Children' (Other People's), And the Horrible Work Ethic

For 200 years Americans have valued the child mainly as a producer — first on the farm, then in the factory and now as a cognitive whiz. Isn't it time to value our children (and our society) for such qualities as playfulness, imagination and love?

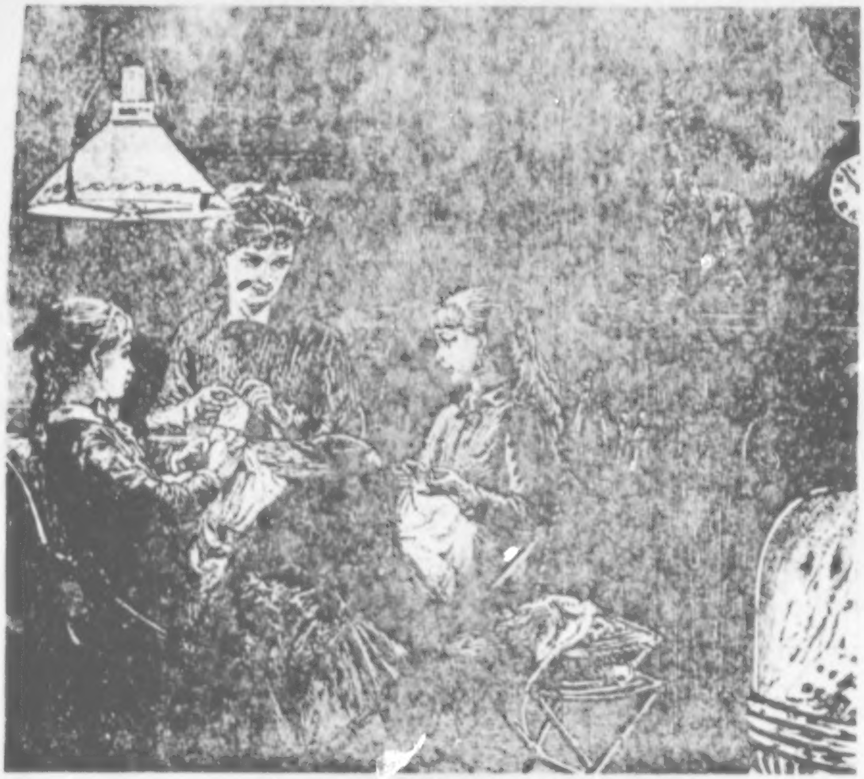
A little over a year ago I became part of a project—the Carnegie Council on Children—whose objective is to assess the needs of American children in coming generations and to present recommendations designed to increase the chance that those needs will be met. Perhaps because many members of our staff have been strongly influenced by psychological thought, some of us instinctively turned toward an analysis of the past as a way of understanding the present and of knowing how to influence the future. For example, in the reports of White House Conferences on Children over the past 60 years, we found a litany of complaints and recommendations. What is striking is how frequently the same complaints and recommendations have been repeated and how little action has been taken to correct obvious abuses.

As everyone knows, America's record in child health is abysmal. Especially for children of minority groups and of the poor, our infant mortality rates are a national disgrace. We are the only industrialized nation in the world that has not adopted some policy of direct family support or child allowance. Of all industrialized nations, we have made the least adequate public provision for the care of young children whose mothers work, even though one-third of all mothers with children under six are now in the paid labor force. Even today significant numbers of American children are malnourished. Mental health services for children are largely unavailable, and our practices with regard to child abuse, foster placement, adoption and the legal rights of children are deplorable by international standards.

Yet we consider ourselves the most child-centered people in the world. Foreign observers have long commented on the preoccupation and solicitude which American parents feel toward their own children. Yet Dr. James Comer, of the Child Study Center at Yale, has said that we can only understand the present by asking why have we not done those things which other civilized nations have done. And Dr. Albert Solnit, director of the Child Study Center, suggested that the most useful question might be: Why do Americans really *not* like children?

More than most nations, we have de-

Kenneth Keniston, professor of psychology (department of psychiatry) at Yale, is director of the Carnegie Council on Children, in New Haven. He is author of such widely selling books as "The Uncommitted" and "Young Radicals."



A scene from "McGuffey's Second Eclectic Reader" (1879).

THE FIRESIDE.

1. One winter night, Mrs. Lord and her two little girls sat by a bright fire in their pleasant home. The girls were sewing, and their mother was busy at her knitting.

2. At last, Katie finished her work, and, looking up, said, “Mother, I think the fire is brighter than usual. How I love to hear it crackle!”

3. “And I was about to say,” cried Mary, “that this is a better light than we had last night.”

4. “My dears,” said their mother, “it must be that you feel happier than usual to-night. Perhaps that is the reason why you think the fire better, and the light brighter.”

5. “But, mother,” said Mary, “I do

53

fined children as future producers and have valued or disvalued them accordingly. The qualities that we have tried to implant in them have been the traits thought necessary for power and status in our economic system. The question that we confront today is whether it is possible for our society to begin to define children in some other way—a way that emphasizes the fulfillment of their potential, not merely as future producers but as unique individuals with a diversity of talents.

Ever since the American Revolution, the prevailing rhetoric about children has been dominated by the work ethic. But work has been valued not because it was a way of maintaining the natural order, nor a form of service to God, nor a way of demonstrating through success that a person was one of the Elect.

First, work was seen as the only way of escaping from scarcity and want. Perhaps for the first time, a large number of people did not accept poverty as man's natural condition, but rather as a disgraceful situation that could be overcome by hard work.

Second, the work ethic presupposed the idea of equal opportunity for the industrious. Admittedly, a large majority of the population has always been excluded from success through work: slaves, Indians, women and almost every dependent minority did not have an "equal chance." Yet historically a number of white working-class and middle-class Americans believed in the vision.

Third, the work ethic is closely related to the American vision of this continent as a vast, and unpopulated area (Indians are invisible) which man can exploit to produce wealth. Without the notion of a limitless frontier, of rich land waiting to be "taken" by work, the work ethic could not have flourished.

This ethic has shaped the qualities that have been most valued and feared in American children for 200 years. Parents have been instructed to teach industry, labor, self-discipline, persistence and thrift. This cluster of interrelated virtues is by far the most frequently mentioned in historical documents on American children from 1750 on. Insofar as children promised to be productive, they were valued. In the pre-industrial farm or shop era, children's work added to the family's prosperity; in the industrial era, the labor of working-class children was an important contribution to the family income; and in the late industrial and post-industrial eras, hard work in school was defined as essential for later success.

"Good children," then, are above all those who promise to be industrious. "Bad children"—usually the children of other people, of other races, classes, nationalities, or ethnic backgrounds—are idle, lazy, apathetic, undisciplined and lacking in self-control. In other words, they are *not* industrious.

At a psychological level, the absence of industry is associated with several dangers. First, the idle child runs a constant risk of falling into vice, which in American history means sexuality, self-indulgence, intemperance, addiction and immorality. The possibility that idleness might promote constructive play, or the development of imagination or fantasy or any virtuous quality, has simply not been entertained until the last 20 or 30 years.

Childhood idleness also has been thought to create what used to be called adult "pauperism," which means deliberate dependency on the industry of others and a tendency not to respect property (the fruit of hard work)—thus, to steal, beg or cheat.

At a social level the absence of industry is associated with urban disorder. Especially in the 19th century, after the great waves of immigration began, the intensity of our American fear of social anarchy is striking. Writer after writer justifies his proposals for child training on the grounds that otherwise a total breakdown of social order will result. The emergent cities of the 19th century were viewed with particular alarm, for their influence on children was invariably seen as pernicious. The evil city, as historians have noted, was starkly contrasted with the good country.

Dependent and indigent children were therefore routinely "farmed out" to the country, sometimes by the hundreds or thousands, so that they would grow up in less corrupting terrain. Active intervention, in the form of special training in habits of industry and self-discipline, was—and still is—called for to prevent a next generation of idlers.

As applied to children, the ethic of industry was ultimately blaming. In most early writing about children and institution-building for them, the line between economic "failure" (poverty) and psychological vice (pauperism) was blurred. Throughout the 19th century, for example, indigent and delinquent children were treated in the same way, sent to the same institutions, farmed out to the same families. Reformers protested that the vast majority of indigent children were in no sense delinquent or depraved. But the practice continued—and, with some modifications, still does.

Given the American belief that a man through hard work could rise to the top, it followed that those who remained on the bottom were less virtuous than those on the top. The poor in America have traditionally been seen as wanting in character or merit, and often as a dangerous influence even on their own children, who would be better trained in "good families," where prosperity attested to virtue, or in schools dominated by the values of the well-to-do.

Our prevailing American fears about children have been similar to our fears of other dependent groups. The qualities feared in children were also thought to be embodied in blacks, Indians and other minorities—they were seen as shiftless and intemperate—and similar epithets have been applied to most immigrant groups. Indians, in fact, were seen as so barbarous that even enlightened missionaries confronted them with the choice of "civilization or extinction." The only way to "save" Indian children was—and often still is—to remove them from the corrupting circumstances of tribal family life where they do nothing but play and thus learn idleness and vice.

The vices of indolence and sensuality were automatically assumed to be far more attractive than the virtues of industry. There is a pessimistic view of human nature inherent in our work ethic. Again and again, one "vicious companion" is seen as "contaminating" all other children. Rarely was the opposite suggested: that one virtuous child might uplift idle companions.

Implicit in this idea is an undercurrent of Calvinism that sees life and child rearing as an uphill battle against natural sinfulness. Schools, families and special institutions for children were all enrolled in this battle. The desperate fear that surfaces full-blown in Victorians like Anthony Comstock is impossible to understand without the assumption that vice is more fun than virtue. Hence the frantic efforts to "protect the young" from bad books and companions.

That the pursuit of prosperity might get out of bounds was acknowledged in some early legislation and institution-building for children, which made token efforts to protect them from physical cruelty and economic avarice. As industrial capitalism developed in the 19th century, more statutes were written to require that "farmed out" or indentured children should go to school, not be overworked and be given minimal rights.

These rights largely consisted in protecting children from the cruelty and greed of their guardians. Yet efforts to protect these rights were generally ineffective because mechanisms for inspection, follow-through or appeal by the child were lacking. Until recently most legislatures were unwilling to enforce protective legislation, and some still are.

But during the late 19th century, Americans began to realize that children could be misused not only by Irish, Italian or East European immigrants, but also by old-stock, native Americans. The early 20th century saw the first American recoil from the most exploitative aspects of industrial capitalism and the call for more humane treatment of dependent minorities, including not only children, but the aged, the poor, and (to a much lesser extent) blacks and other non-North European Americans. The first White House Conference on Children in 1909 is a very pure—indeed classical—expression of the new spirit of Progressivism as applied to children. Nevertheless, federal laws outlawing child labor were deemed unconstitutional, and in the 1920's a constitutional amendment to forbid child labor failed to be ratified. Even today, Americans resist efforts to define the child as other than a productive-industrious citizen of society. Erik Erikson argues that industry is the great theme of later childhood.

Although the stress on psychological industry is a constant in our history, the meaning we have attached to the concept of industry has changed with the changing needs of the economy. In 1790 America was overwhelmingly an agrarian and agricultural nation. In 1890 the move from the farm to the city was well-advanced, and the dominant sector of the American economy was the industrial sector. Today, in contrast, primary production has diminished enormously, and workers in factories and assembly-lines constitute a dwindling minority in the labor force. Ours is increasingly a service economy, with more and more workers employed in providing services to each other.

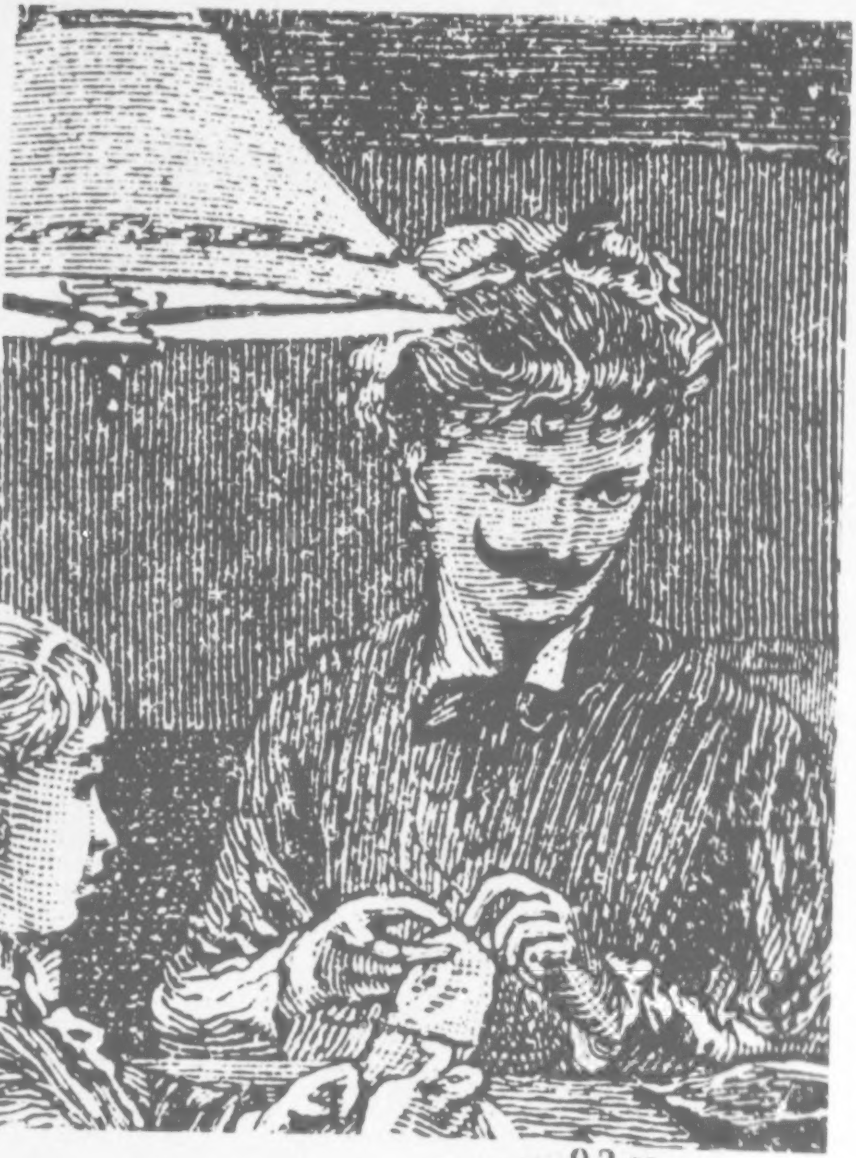
These shifts in the economy inevitably entail shifts in the labor force as well. Farm labor in the late 18th century consisted of sheer manpower. Men, women and children, working long hours in the fields, were essential to economic productivity.

By 1900 the factory worker required

not see why we are happier now than we were then; for last night cousin Jane was here, and we played 'Puss in the corner' and 'Blind man' until we all were tired."

6. "I know! I know why!" said Katie. "It is because we have all been doing something useful to-night. We feel happy because we have been busy."

7. "You are right, my dear," said their mother. "I am glad you have both learned that there may be something more pleasant than play, and, at the same time, more instructive."



different qualities from the farmer: punctuality, obedience and discipline. He also needed skills of a higher level for success in an industrial society—literacy, for example. And if he were to move to a still higher level of entrepreneurship, still other qualities were required: drive, ambition, competitiveness, even a certain ruthlessness. Thus not only new technical skills but a new kind of social character was required on a mass scale.

Turning to the present, we are entering still another kind of society, one which is knowledge-based and which requires still different human qualities. Educational criteria are a prerequisite for entry into higher positions. Meanwhile, thrift, drive and ambition have receded in a corporate industrial state, their place taken by skill in interpersonal management and manipulation, the capacity to integrate large amounts of information, to deal with abstractions and complex technology. So again our society has changed both in the skills that it rewards and the social character that it must "produce."

What has this meant in terms of the qualities that we deem desirable in children? I have stressed the enduring emphasis on hard work. In the agrarian era this meant hard work on farms and in fields—a kind of muscle power. But with industrialization the meaning of industry shifted, emphasizing what can be called willpower.

For example, in the 19th century there appeared in the literature on child-rearing a new emphasis on self-control and a fear of its absence. Writings on childhood became increasingly psychological; they emphasized the importance in children of deeply ingrained character traits, many of them perceived as opposite to the so-called "natural inclinations of the child."

Today the definition of industry is again undergoing a drastic change. In working-class families, the industrial virtues of willpower remain central in child-rearing and schooling. But among the aspiring—in middle-class and especially upper-middle-class families—industry has assumed a new meaning. Let us call it brainpower. From a terror of lack of willpower and control, we are shifting to a terrible fear of cognitive underdevelopment. Work is increasingly defined as head-work; our greatest concern for our children is that their cognitive development will somehow be impaired.

Enlightened liberal opinion now

views the greatest problem among the poor as that of cultural deprivation, which means poor performance in school, cognitive understimulation, bad reading scores, and so on. A child who is valued, thought likely to succeed and rewarded by being "tracked" into the higher levels of school, is a child who performs well cognitively. Despite protests from those interested in other aspects of human development, our "intervention programs" with other people's children have stressed with monotonous uniformity the importance of cognitive and intellectual stimulation in the early years. And in middle-class families and schools the greatest terror and most common problem is "the learning problem." In two centuries we have moved from muscle power to willpower to brain power.

This has been accompanied by a fundamental shift in the economic meanings of children to their families. In an agrarian society, children were an essential source of free labor. In the later industrial era they became either a source of cash income or a form of social insurance—they would provide support when their parents were old. Today, from an economic point of view, children are an unlimited liability. They consume large resources, none of which can be expected to be repaid. Whatever payoff a family receives from children must be derived from the intrinsic satisfaction that adults derive from the process of rearing children. Thus children have shifted during two centuries from being a source of free labor to being a source of income and social insurance to being an economic disaster.

Another changed issue is the relationship of children to the parental generation. On the pre-industrial farm they were more or less replicas, destined for the same life as their parents. In the industrial era they became the embodiment of their parents' dreams—not expected to live out their parents' lives but to fulfill their parents' ambitions. Today our view of children is becoming far more qualified and darker. The first child or two may indeed be seen as a source of gratification and a necessary fulfillment. But the third, fourth, fifth or further child is seen as a self-indulgence. Indeed, large numbers of children are now perceived as harbingers of ecological doom.

In general, there are two ways of using this understanding of the past. The first is to take the past as a portent of the future. If we did, we would see it as inevitable that our society would continue to to value children primarily as productive participants in the economic process and to disvalue them if they were not considered potentially industrious.

The second use of history, familiar from the practice of psychotherapy, views an understanding of the past as a necessary precondition for change. The past is coercive only when we fail to appreciate its power—we can be freed from its compulsiveness if we can appreciate its meaning, and re-direct ourselves toward a future that does more than simply recapitulate.

Whether we should continue to define our children primarily in terms of their future productive roles is a question to which I have no simple answer. Let me only suggest a few thoughts.

First, we live in a nation which, whatever its faults and current mood of despair, has achieved a higher level of prosperity than any society in world history. Some people would deprecate this, or point to the price that we have paid. Nevertheless I do not think we can merely dismiss it. Nor should we be oblivious of the fact that most of today's children will work in an economic system that will be highly technological and will need to be prepared for a productive role. In other words, however easy it is for us to mock the virtues of industry and the extraordinary stress we have placed on it, it will be important to continue to place at least *some* emphasis on these qualities. It is hard to imagine any livable society in which children are not brought up to value and be capable of productive work.

Yet we pay an enormous price for our emphasis on industry as the supreme virtue of childhood, and this price is one that cannot be understood solely by talking about children. It involves the neglect or suppression by our entire society of other human values, goals and qualities. Our current definition of industry in the young leads to our national obsession with reading scores, I.Q., cognitive stimulation, reading readiness, learning disabilities, intellectual impairments and so on. In human terms this means that children who are equipped by environment, parental training or heredity for success in the cognitive rat-race are most highly valued, while those with other skills are relegated to the bottom of the human scrap heap.

Thus we run the risk in America today of having only one hierarchy of human value: cognitive ability. With this approach both individuals and society pay a high price. Even for those who play the cognitive game well, the price is too often an atrophy of other human qualities which I suspect are, in God's eyes, far more important: morality, kindness, empathy, feeling, joy, imagination, playfulness, grace, artistic ability—to say nothing of love. And the price paid by those at the bottom is all too well known—children who by second grade have accepted the label of "losers" and who carry it with them forever.

What we lose is the extraordinary diversity which might flourish in this nation of diverse origins. If all other human qualities are neglected before intellectual-cognitive precocity, then all the individual endowments, the diversity of cultural traditions that make up this country, will remain unrealized.

One cannot consider children without considering adults and society, and one cannot consider the future of children without considering the future of mankind. There is no escaping the question of our deepest values. At the Carnegie Council we differ from Michael Young's negative utopia of a meritocracy in which each person's position will be determined by his I.Q. Our alternative vision is still vague, but some of its components are clear. It is a vision of a society which, without deprecating work, would place equal emphasis on other human qualities such as love, care, compassion, grace and imagination.

It would be a society where the lip service that we now give to the unfolding of individual talent in children would be concretely embodied in families and neighborhoods, child-care centers and schools. It would be a society where, instead of asking how good children were at schoolwork, we sought to cultivate whatever was strongest and deepest in them and in their cultural tradition, whatever would enable them to be most fulfilled and of greatest use to their fellows. It would necessarily be a society re-structured in many ways radically different from our own.

Thus I end where I began. Our research so far has perhaps done little more than teach us that children are a reflection of the society in which they exist: that the ways in which we care for them (or fail to care for them) reflect the deepest assumptions of our society, and that it is not possible to imagine a society that cared more tenderly for its young without also imagining a society that was more humane and caring to those who are not young.

The National Observer
February 22, 1975

Subtle Neglect

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Is U.S. Becoming Less Child-Oriented?

By Sarane S. Boocock

THE PAST decade has witnessed a countertrend away from the Spockian child-centeredness of the 1950s and early 1960s. Not only is there accumulating evidence that many American children are not being adequately cared for, but there are also indications of a general devaluation of children and child rearing.

Comment

The available evidence on abuse, neglect, and other indicators of inadequate care are difficult to evaluate. The magnitude of the child-abuse problem, for example, can only be estimated. Some 60,000 cases a year are reported in the United States, but on the one hand, part of the apparent increases in the incidence of abuse may be due to fuller reporting; on the other hand, many cases, especially in middle- and upper-income homes, go unreported.

What constitutes neglect of a child is still not clearly defined, and the indicators of neglect take a variety of forms. There have been increases in the number of divorce cases in which *neither* parent wants custody of the children. There are clues that many children ostensibly in the care of their own parents are, in fact, left without care for long periods of time.

This kind of information is difficult to obtain, since few parents willingly admit to leaving young children unattended. A 1966 Swedish study found some 3,000 children under 7 years of age left unsupervised while their parents were at work. A study by the Child Welfare League estimated that in 1965, almost a million American children under 14 were left on their own while their parents were at work, of whom 7,000 were under the age of 6; another million were left in the care of older brothers and sisters under 16 or relatives over 65. At recent Federal and state hearings, a number of working-class women testified that they had left ill preschoolers unattended in locked apartments because they feared losing their job if they stayed home with them. . . .

Preschool children left alone in an apartment while their parents are at work are obvious cases of neglect, but there are some more general and subtle trends that suggest that our entire society may be becoming less child-oriented. Crossnational time studies indicate that Americans are spending less time in child care than they did in the past, less time than parents in other countries for which time data are available.

This article is excerpted from a paper that Dr. Boocock, a sociologist with the Russell Sage Foundation, gave in January at a symposium during the annual meeting of the American Association for the Advancement of Science.

Ironically, American women are spending more time than ever on housework, but large amounts of this time are devoted to the care and repair of "labor-saving" appliances and to the shopping that is an important component of a consumption-oriented society. Moreover, a large chunk of many mothers' "child care" time is spent in chauffeuring their children. As Alexander Szalai notes: "Two marked curiosities of the United States data are how little time is spent helping children with homework and how much time is spent transporting them."

Few studies exist of how much and how parent-child time is actually spent, although some informants estimate that even nongainfully employed mothers may spend as little as 15 or 20 minutes a day in actual communication with their preschool children and that many children have no other daily meaningful contact with adults.

Fathers spend even less time with their children. Henry B. Biller's own research and his review of the few studies that have been done indicate that the majority of American fathers spend little more than 10 or 15 minutes a day in one-to-one interaction with their preschool children, although there are large individual differences, with a few spending as much as two hours a day with infants.

Preliminary analysis of children's diaries collected by the author and her students and colleagues for a nonrepresentative sampling of communities in New York state and on the West Coast indicates that children not in school spend most of their time alone or with other children (there seems to be some tendency for big-city children to spend less time than suburban or small-town children with friends), mostly in relatively unorganized activities such as watching television, eating snacks, and "fooling around."

Few spend as much as two hours a day with an adult other than a teacher, and few meals are eaten together as a family. While a few children go shopping with their mothers, almost none do errands or chores or contribute in any other way to the running of the home, and rarely does a child work with an adult on some project or even observe an adult at his work (in contrast with, say, an Israeli kibbutz, where children not only work in the community themselves, but also daily see their parents and other adults engaged in their regular work).

We did interview some children in small towns and rural areas who regularly ate meals with their parents and who helped around the home in some way, but the large amounts of television viewing and the small amount of time with adults seemed to prevail everywhere.

It seems fair to conclude that the status of children in our society is highly ambiguous. It is clear that the traditional reasons for wanting children —i.e., for economic reasons or to extend the family line or family name—have all but disappeared in modern secularized societies.

It has been argued that as children have lost their economic and familial value to parents, they have become more valued in a qualitative sense, as they provide adults with personal experiences and pleasure of a unique sort. Evaluation of this argument requires an understanding of some very complex demographic trends as well as weighing of what little survey data are available on the subject.

It does seem that there is less wanting of children in America, and in developed nations generally, than in the past and that people who do want children want fewer of them. However, we still know very little about people's reasons for wanting—or not wanting—children, nor do we know much about their attitudes and behavior toward the children they have.

Moreover, examination of the role of the child (role defined as a location in a social system with the rights and obligations attached to that position) indicates that it is unbalanced and becoming more so. Child-development models which focus upon obtaining ever finer knowledge about the special characteristics of each stage in the child's life and upon maximizing cognitive, emotional, and social development at each stage have a lot to say about children's rights but are virtually silent on the subject of obligations. . . . Cross-cultural work suggests that children, like other social beings, can only be integrated into the larger society if they make some kind of contribution to it, and that their self-esteem depends upon their having obligations as well as rights.

THE WASHINGTON POST
B 6 Friday, April 30, 1976

Book World

Imprisoning Our Children

WEEPING IN THE PLAYTIME OF OTHERS: America's Incarcerated Children. By Kenneth Wooden.
(McGraw-Hill. 264 pp. $8.95)

Reviewed by
Colman McCarthy

The reviewer writes for The Washington Post's editorial page.

A case is easily made that America, far from doting on its children, actually hates them. Much of this loathing has been institutionalized, so that only the occasionally deranged molester on the street or the child abuser is seen as dangerous. But what of the children who are killed and injured every summer because Congress has failed for 10 years to pass a youth camp safety law? Or the suffering children of runaway fathers? Or the children in rural America who must live in shacks because the government subsidizes housing for the middle class more than for the poor?

The term "child abuse" has a narrow legal definition, but for the victimized child it matters little whether he is brutalized directly by a crazed adult or obliquely by a political system that treats him as worthless.

It is hard to get reporters to examine the methods by which poilticians, business interests, bureaucracies and the courts institutionalize America's hatred of children, but Kenneth Wooden is one exception. For about three years, as a free-lance writer getting by on grant money, he travelled to 30 states seeking to explain why some 100,000 children between the ages of 5 and 16 are imprisoned, though a majority have committed no crime. The closets in which the children are stashed are called detention centers, reform schools or training schools, with some of them called "homes," "ranches" or "hospitals." Wooden came upon a national industry that he describes as "a tyrannical monster, destroying the very children it was mandated to save."

He is clearly angry at what he found—every degradation from solitary confinement to injections with behavior modifying drugs—but he is interested in being more than a tour guide through another of America's hells. His book's value lies in its examination of causes, and how the decisions of public officials, though remote, are related to the demeaning of children in lone cells. "If one could scrutinize the financial structure of juvenile facilities with their immense budgets and multiple institutional needs, one would find most of them riddled with conflicts of interest and naked corruption. Clear-cut examples of this include some Georgia jails that have 'turn-key fees' and refuse to release children until their parents have paid the local sheriff room and board."

In another state—Illinois, before Gov. Daniel Walker's administration — "memos would come down from the governor's office commanding the Youth Department to send children to select private facilities because their census counts were low. Children were herded off like cattle to enhance profits enjoyed by the business cronies of local politicians."

Locked within the state's institutions, the children also are imprisoned within the walls of their own handicaps; the severest is often illiteracy. Wooden argues persuasively that early difficulties with reading are major causes of later incarceration. "For the child who falls behind, who hears such words as 'dumb' or 'retarded,' 'nonreader' and 'failure' . . . the damage to his self-esteem is almost certainly irreversible. These years of educational failure shatter the self-confidence of the child. Failure leads to frustration and hopelessness, which in turn can lead to aggressiveness. . . ."

Wooden knows something about children on whom the schools give up and who turn to violence. In a moving account of his own boyhood, he tells of teachers dismissing him as "dumb and slow." He turned to vandalism, and only after the Army took a chance on him—he was a library assistant — did he go back to school. The same high school that once gave him an IQ rating of 78 hired him years later to teach.

To correct some of the abuses now suffered by imprisoned children, Wooden asks that Congress create a "National Child Health Care Enforcement Agency," pass a "National Suicide Prevention Act for Incarcerated Youth" and that the country establish a "Bill of Rights for Children." Wooden is sane and compassionate in advancing such ideas, but he is up against a Congress that is part of the system that institutionalizes hatred for children. It is happy to spend $21 billion on the B-1 bomber but only provides $13 million a year for the National Right to Read program.

Wooden can write that "unless we take drastic and bold steps to improve the quality of education at a basic level, children in increasing numbers will fill the youth jails and later the adult prisons," but in Washington that is passed off as softheaded liberalism. It is a realist like Gerald Ford who has a solution: in his State of the Union message, he called for the construction of four new federal prisons.

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Wrecked Parents, Brainless Love

They've No Right To Destroy the Children

'The dirt will thicken on Bennie's neck and wrists, and in some way it will penetrate his spirit. One day he will explode. . . .'

The Washington Star, June 8, 1975
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By Ned O'Gorman

In New York City, the children of the oppressed are under sentence of death. The very young, babies just born, are thrust from the beginning into a world learned in ways of slaughter. No time for saving them, the die is cast in the cradle. Death proceeds on its way to blight their bodies and their spirits. Hope, joy, wonder, all are mauled, wrecked and fated to end in the grave, whether that grave be the streets, jail or some well-tended cemetery.

Ned O'Gorman is a New York poet.

This article is reprinted, by permission, from the New York Times Magazine.

I write of New York City, Harlem especially. I have worked there nearly 10 years in a nursery school I started in 1966. (I call it a liberation camp. It is privately supported, and we get no government aid. We accept any child who comes to us, feeding each breakfast and lunch.)

I will write of children I know now and have known in the past. They came to us out of torments that would make stones weep. I write of what I have seen. I have added nothing. I have imagined nothing. I have seen poor white children in Kansas, Irish kids in Dublin and boys in Chile slipping as quickly as Harlem children into the abyss.

The children I see each day are dying. I must ask myself what I can do to release them and their kin from the killers that have pursued and caught them. I am in Harlem, then, to save children from their guardians (blood kin or not), from the streets and the oppressors in all their masks. The law suffers from an overwhelming passivity in the face of this epidemic of child abuse and its attendant horrors. There are not enough investigators to probe into the lives of these children; and once the process is begun, the change sought in their lives takes months of tedious red tape to get underway and often simply peters out. Families move, refuse to give the child up, suffer momentary change of heart, deposit him in the hands of respectable kin for a while and abort investigation.

It is time now for agencies and individuals who hold themselves responsible for the lives of these battered, suffering children to study with vision — and science — the meaning and function of the family, to ask whether a family has the right to impose its destructive manners and style on the innocent and to find ways to bring change into these children's lives with curative intensity. The community, the state, the churches, the courts, the law, politicians, educators must say *No!* to those who cripple children. They must offer them a revolutionary purpose and stop the slaughter.

What we all must seek is a way to speak for the children of the oppressed, a way to become their surrogate will to live. We must seek, too, to tell the oppressed that they are oppressed and that unless they move to change their lives, the state in its work with these children will simply have to become a tyrant to be effective.

In three rooms of an apartment above a dry cleaner, Tommy lived with his mother, her friends and roaches. He was 2. Since his birth, he had been constantly sick. Lead poisoning had landed him in the hospital for a month. His skin was ashen. He slept all day, seldom ate and stagger-

See CHILDREN, B-4

CHILDREN

Continued From 3-1

ed into my school now and then, when I could persuade his mother to let him come or when she needed us to babysit. The spirit had gone limp in him and from his eyes shone a fabrication of life.

One morning, one of our workers told me his mother had sold him to a woman she met in a clinic. I bounded up to Tommy's flat and found him there with his mother and a strange couple. The woman had Tommy in her arms. His mother sat by the stove. I asked if she had sold him. She said no: She had given him to those people. How much, I asked, did you get? She said, "I did not sell him."

I went back to my school and asked the workers for more information. She was paid $800 for him, they told me. I phoned a friend in a child-care agency and asked what I ought to do. I phoned Tommy's mother's social worker and asked her to come up to talk to all of us. My God, I thought, you simply cannot sell a child.

The social worker investigated and made calls here and there, and by the end of the day some agreement had been reached that the prospective parents in the clinic and Tommy's mother would meet the next day with the Bureau of Child Welfare. They never did. Tommy, mother and couple vanished.

I saw Tommy some months afterward with his natural mother. I asked her where he lived. She said in Brooklyn. I looked in Tommy's eyes. He was dead.

Recently I heard that she had had another child and sold it on her first day home from the hospital.

Why did I have to go through such trouble to get little Tommy out of the clutches of his mother and those buyers? My effort to become Tommy's surrogate will was a failure. I had no power. I had no proof. The social worker seemed bland, bored and so fearful of hurting people's feelings that from the beginning I knew Tommy was going to be sold and there was nothing I could do about it.

Carita loves Lennie. I do not know many mothers who can say, as she does, with such depth of feeling, "I love my son." She would willingly give him all that is good, but she is unhinged, wrecked — and a victim. Her past was filled with troubles. She drank and seemed to have little will to fend off men. Her apartment was a ravaged horror roaches in the icebox, urine-soaked sheets in piles on the floor, broken glass everywhere.

Lennie, 9 years old, fragile, overwhelmingly lucid, wandered around, missing nothing, watching his mother destroy herself. His brother, brain damaged, a hulking 6 year-old child, overweight, stumbling, voiceless, lurched about the rooms. Once, he nearly drowned in a tub filled with filthy water. Twice, Carita set fire to her bed, and twice Lennie called the Fire Department.

Agencies came and agencies went. Men with serious intentions appeared, judged what they saw as horrendous and did nothing. One fellow gave her a month to improve her lot, get to Alcoholics Anonymous and straighten up her flat, but I told him she never would be able to do it and indeed she didn't.

I said if Carita wanted to go to hell that was her business; it was our business to save Lennie. But everything was covered with a hushed kind of good manners. ("Carita's privacy must be protected," a good lady told me.) I knew it was going to be impossible to do anything. It was as if I stood on board a ship and deliberated with the captain if we ought to throw a life jacket to a drowning child before we got his mother's permission.

Lennie hung on. I picked him up in the mornings to take him to school. His little body and spirit were large enough at that moment to store away the nightmares in some corner of his mind. In a week, though, he began to fly into rages, run away from school, sulk, make up tales, refuse to do class work and weep when I had to return him home. By then, Carita had a new gentleman caller. (One day, Lennie saw a stranger rape his mother.) Lennie spent the hours away from school on the stoop of his apartment house in the midst of one of the worst heroin quarters of the city. Finally, after months of hassling, he was made the ward of a good woman with a house on Staten Island. It took four years to get him there. Carita once said to me, "I love him so, but, Ned, I don't know what to do. Help me, Ned." I could not. No one could.

A few days ago, I discovered that Lennie must now leave his foster home. He will be sent to a therapeutic school in the country. The past has taken its vengeance on him. He is still a vibrant child, but the fabric within him is crumbling. The foster care he received was absurd from

the beginning. His father whom he sees twice a year will not free him for adoption. His surrogate will to live has not been heard. Thus, the agencies and schools responsible for him will have to share the burden of Lennie's fate.

I know that what I have reported, even though I have seen it all happen, will be criticized as being gloomy, as casting doubt on an entire community's ability to care for its children. It think that such a criticism is in part justified. I *am* gloomy. I *do* criticize the people of the community as much as I criticize — attack, I think — the law, the church, the government on every level, in their indifference to this slaughter of the innocent.

Stella is 3 and nearly mute. There is nothing clinically wrong with her. She merely does not know yet how to talk. (Often, the first faculty that has been stricken in the children we meet in our school is their ability to speak. It is usually diagnosed as a speech defect, but most often I have found it to be simply the result of hearing bad English, listening to nothing but television and being spoken to hardly at all.)

Stella's mother stands in the doorway of her apartment like a chained totem. Stella smiles a mute smile when I see her in the morning, jumps up a little and runs toward me. She looks at nothing, recognizes nothing. She has no notion of what to do with toys, blocks, crayons, scissors.

She loves to play with Link, a boy of 3, who, like Stella, has developed over the months, since he has been coming to my liberation camp, from a screaming, weeping mess into a beautiful little boy, stricken but fighting to know his world. Stella, mute, Link, awash with nerves and chaos.

Link's mother, like Stella's, is a woman of intense unhappiness. Her life, her children, her flat, all are in a state of *rigor mortis*. Nothing changes from day to day; her eyes grow duller and duller; she never laughs, and the children take on her morbidity.

I do not doubt that the mothers I write about love their children. Yet it is a love that lacks patience, understanding, science. I love flowers. I do not think any sight in this world delights me more than a crocus. But the intensity of my love does not qualify me to become a curator in the Brooklyn Botanic Gardens. I have not one whit of knowledge of how to prevent blight, how to stem a ravaging weed. Nor do I know the difference between a rare tropical plant and poison ivy. I have a brainless love of flowers, as Stella's mother and Link's have a brainless love for their children.

Stella is a victim, as a flower might be, and her future lies in her mother's power over her. It is absolute power.

Nate rules his household with irrepressible violence. His five children are all broken figures, products of their parents' tragic battles that rage day and night. The household reverberates with barrenness: broken furniture, a refrigerator that does not work and a berserk television set.

Bennie, at 5, is so dirty that when I lift him onto my shoulders dirt flakes off his wrists and neck. None of the children can yet speak one clear sentence. (Their ages are 1 to 11.) Welfare evicted them from their flat. Now they are living in a hotel downtown until they are moved into a housing project. It will be the same there, one house of torment to another. The dirt will thicken on Bennie's neck and wrists, and in some way it will penetrate his spirit. One day, he will explode, do violence to himself, or to another, and the headlong plunge toward death will be over.

Daniel, now 19, came to my school when it first opened. He was 9 then. A year ago, I saw him in a doorway on 128th Street. I had remembered him as one of the loveliest kids on the block. He had a special kind of hilarity about him, a clean, direct presence. But when I said hello he looked at me, eyes and body in an embattled, razor-sharp fury. I walked down the street and turned once toward him, and he heaved a Coke bottle at me. I ducked. He missed me by an inch. I've not seen him since.

I seek in my work the power of the surrogate will. Mute Stella, Lennie, Link, Tommy and others I've known would have survived had some law imposed healing in time. (Am I saying these children are lost? I think I am.) The space that lies between a court's or an agency's awareness of a child's agony and the removal of that child from the locus of destruction is often the space in which the final sickness takes over with such intensity that no matter what happens later the game for that child is up.

What can I suggest as solutions to the calamities mentioned here? Is it, first, perhaps a problem of literacy — not merely the ability to read and write but the ability to read one's own place in time? The ability to see what is happening around one's family, within the home, in the streets. I must find a way to teach the oppressed man and woman how to decipher the oppressing world so that they can wage war against it.

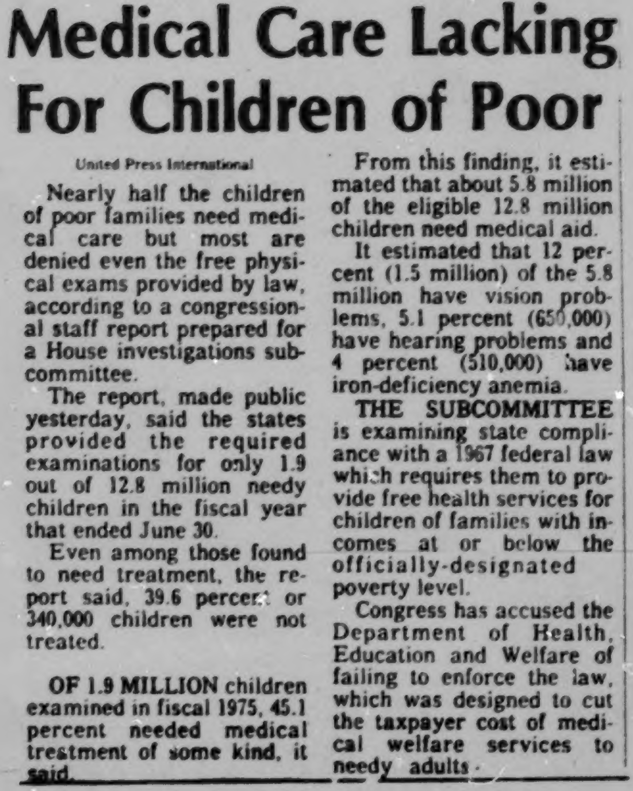
What I seek is a revolutionary literacy. Might not a massive effort by the state and city to invade the streets with 24-hour centers of healing be a beginning toward this new awareness of life? I think of storefronts where parents could get quick help in problems of nutrition, rashes, earaches, bruises, colds — all those debilitating crises that can, if never seen to, infect a child's growth; libraries and minischools where people could come to read, talk, draw, even watch television, where the oppressed could begin to come into contact with the bounty — not the debris — of the world. I think of all the space that goes to waste in Harlem.

I think of the block, how it could be such a force for change. If there were some folk on the block who could organize a kind of court where troubled parents could come and seek help, then perhaps the sense of alienation that Carita feels might burn into a sense of hope.

But, in this land, such an act of communal ardor is hard to achieve. In China, where I visited in 1973, it has been achieved, but here in our community where everyone seems to know everyone's business, where not a sparrow which falls or a child who dies goes unrecorded in someone's memory, there is a vast silence, a reticence that allows things to proceed on their deadly course with hardly a sigh to note the carnage.

Would it be possible for the Rockefeller Foundation and the Ford Foundation together to build a community of healing in Harlem, with a staff of doctors, nutritionists, teachers, psychiatrists, ministers (if they were needed), lawyers, judges, scientists who would give their time to discovering ways of creating a revolutionary life?

But such a community of healing must have behind it some clout so that, as I have mentioned before, if Carita refuses to go, it will be made clear to her that Lennie must — or he will be hauled off, now or later, young or old, in a cheap coffin, perfectly dressed, to a grave in an earth that nourished the evils that killed him.



Medical Care Lacking For Children of Poor

United Press International

Nearly half the children of poor families need medical care but most are denied even the free physical exams provided by law, according to a congressional staff report prepared for a House investigations subcommittee.

The report, made public yesterday, said the states provided the required examinations for only 1.9 out of 12.8 million needy children in the fiscal year that ended June 30.

Even among those found to need treatment, the report said, 39.6 percent or 340,000 children were not treated.

OF 1.9 MILLION children examined in fiscal 1975, 45.1 percent needed medical treatment of some kind, it said.

From this finding, it estimated that about 5.8 million of the eligible 12.8 million children need medical aid.

It estimated that 12 percent (1.5 million) of the 5.8 million have vision problems, 5.1 percent (650,000) have hearing problems and 4 percent (510,000) have iron-deficiency anemia.

THE SUBCOMMITTEE is examining state compliance with a 1967 federal law which requires them to provide free health services for children of families with incomes at or below the officially-designated poverty level.

Congress has accused the Department of Health, Education and Welfare of failing to enforce the law, which was designed to cut the taxpayer cost of medical welfare services to needy adults.

The Washington Star, October 12, 1975
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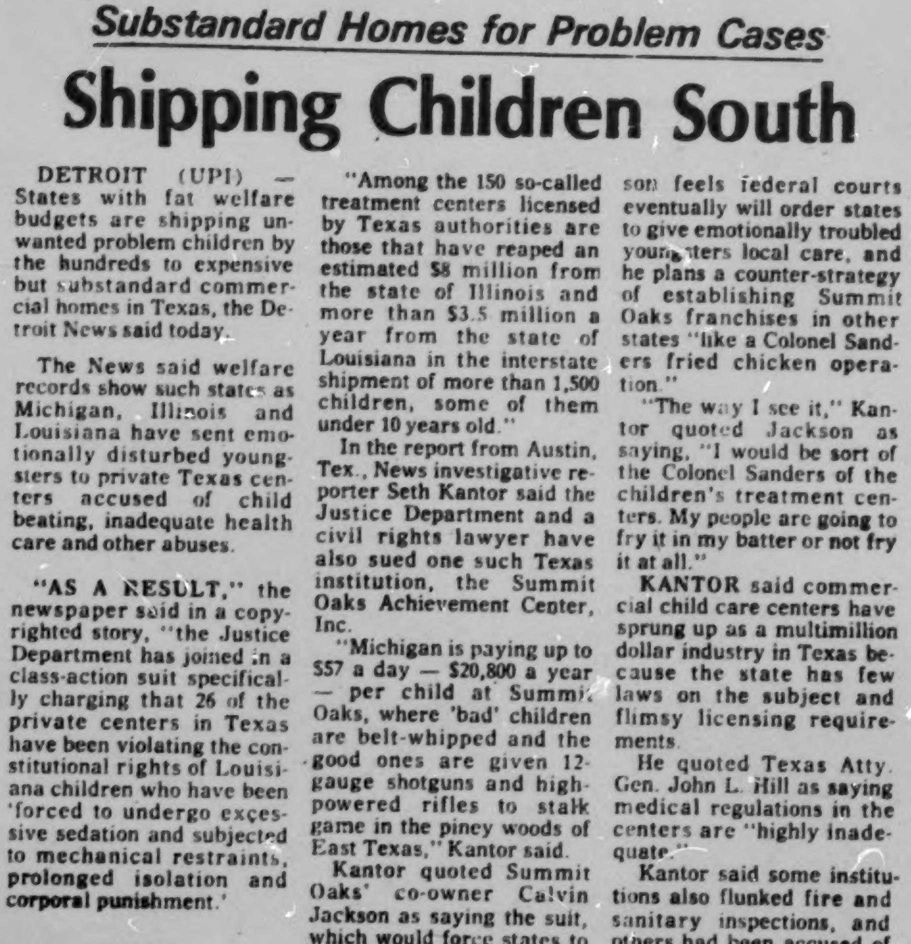

Substandard Homes for Problem Cases

Shipping Children South

DETROIT (UPI) — States with fat welfare budgets are shipping unwanted problem children by the hundreds to expensive but substandard commercial homes in Texas, the Detroit News said today.

The News said welfare records show such states as Michigan, Illinois and Louisiana have sent emotionally disturbed youngsters to private Texas centers accused of child beating, inadequate health care and other abuses.

"AS A RESULT," the newspaper said in a copyrighted story, "the Justice Department has joined in a class-action suit specifically charging that 26 of the private centers in Texas have been violating the constitutional rights of Louisiana children who have been 'forced to undergo excessive sedation and subjected to mechanical restraints, prolonged isolation and corporal punishment.'

"Among the 150 so-called treatment centers licensed by Texas authorities are those that have reaped an estimated $8 million from the state of Illinois and more than $3.5 million a year from the state of Louisiana in the interstate shipment of more than 1,500 children, some of them under 10 years old."

In the report from Austin, Tex., News investigative reporter Seth Kantor said the Justice Department and a civil rights lawyer have also sued one such Texas institution, the Summit Oaks Achievement Center, Inc.

"Michigan is paying up to $57 a day — $20,800 a year — per child at Summit Oaks, where 'bad' children are belt-whipped and the good ones are given 12-gauge shotguns and high-powered rifles to stalk game in the piney woods of East Texas," Kantor said.

Kantor quoted Summit Oaks' co-owner Calvin Jackson as saying the suit, which would force states to bring their children home from the Texas centers, is "unfair" and "like bringing a bunch of preachers into court."

But, Kantor said, Jackson feels federal courts eventually will order states to give emotionally troubled youngsters local care, and he plans a counter-strategy of establishing Summit Oaks franchises in other states "like a Colonel Sanders fried chicken operation."

"The way I see it," Kantor quoted Jackson as saying, "I would be sort of the Colonel Sanders of the children's treatment centers. My people are going to fry it in my batter or not fry it at all."

KANTOR said commercial child care centers have sprung up as a multimillion dollar industry in Texas because the state has few laws on the subject and flimsy licensing requirements.

He quoted Texas Atty. Gen. John L. Hill as saying medical regulations in the centers are "highly inadequate."

Kantor said some institutions also flunked fire and sanitary inspections, and others had been accused of taming violent children with heavy drug doses. Few of the homes measure up to child-care standards required by law in the childrens' home states, Kantor said.

The Washington Star, June 15, 1975
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Ellen Goodman

Child-Snatching

The Washington Post
March 26, 1976
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BOSTON — Usually, the cases are less dramatic. They rarely involve a speeding car and a captured gun, or private planes waiting at a New York airport. Usually they don't make the evening news or page one of the morning papers.

Usually the cast of characters isn't as rich or renowned as Pittsburgh millionaire Seward Prosser Mellon and his ex-wife Karen Boyd Mellon.

But aside from the notoriety that surrounded the grubby abduction of two frightened little girls in front of a two-family house in Brooklyn, the event was almost common.

It is a tactic used with appalling frequency in vicious custody battles all over the country. It's called: Take the Children and Run.

It's happened now twice to the Mellon children, ages 5 and 7. The first time it was their mother who snatched them while they were visiting and took them on a four-month journey through 14 hotels, under nine different pseudonyms. The second time it was their father or, rather, their father's hired men who posed as FBI agents and carried them back again.

But the "game" is played by others. As the number of divorces increase, so do the number of vigilante parents who are taking the custody laws into their own hands. And some groups estimate that 100,000 child-snatchings occurred last year alone.

The victimized parent—one who doesn't know where his or her child is—is almost helpless. According to a Washington-based group, Children's Rights, Inc., which handles dozens of these calls every month, the victimized parent gets little support from the police "They consider it a domestic matter. They say, 'We don't want to get involved in family problems,' " says the group's Arnold Miller, who hasn't seen his own 6-year-old son in a year.

The FBI is no help either, although most of the children are taken across state lines. It's "out of their jurisdiction," because parents are specifically exempt from the federal kidnapping statutes. The parent who "steals" his child can't be accused of kidnapping.

On the other hand, the parent who abducts his or her children can often gain legal custody of them in another state. In the confusion of custody laws that change at the borders of states as if they were ancient principalities, a parent can comparison shop until he or she finds the best deal.

There are at least two ways to reduce the attractiveness of this self-help tactic. The first is to make parents legally liable for prosecution if they kidnap their own kids.

A bill sponsored by Rep. Charles E. Bennett (D-Fla.), which has been languishing in the House for three years, would remove the exemption of parents from the kidnapping statutes and would punish them with a $1,000 fine or a year in jail, or both.

It would make federal files—including Social Security information, Internal Revenue returns and prison records—available to police searching for the abducting parent.

Another help would be the adoption of the Uniform Child Custody Act, which is currently used by seven states. This act standardizes custody guidelines and insures jurisdiction rights. A parent who was unhappy with a decision would have to challenge it in the home state instead of simply trying another.

The point is the children, the shuttlecocks in the parents' game plan. The Mellon children are only two of tens of thousands. Child-snatching may be "a family matter," but parents don't own their children, their children's rights, lives or feelings.

We protect children from other kinds of parental abuse—battering, neglect, sexual mistreatment. This case has dramatized another need. We have an equal obligation to protect children from being rustled like cattle back and forth across the borders.

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Washington Post Writers Group

UNIT II

The Nature of Child Maltreatment

II. The NATURE of CHILD MALTREATMENT

--- What Is It Like?

UNIT II. THE NATURE OF CHILD MALTREATMENT

Instructional Objective for Unit II

THE STUDENT WILL BE ABLE TO DISTINGUISH THE NATURE OF CHILD MALTREATMENT FROM ACCEPTABLE OR USUAL CHILD REARING PRACTICES IN SOCIETY TODAY.

Generalizations for Unit II

A. Child maltreatment is described as acts of physical abuse and/or neglect and acts of psychological abuse and/or neglect on the part of a caretaker.

B. Child maltreatment is manifest in physical and psychological damage in the child.

C. Child maltreatment is distinguishable from acceptable or usual child-rearing practices in society today.

Performance Objectives for Unit II

1. STATE the federal definition of child maltreatment.
2. IDENTIFY the caretaker.
3. DESCRIBE typical acts of physical and psychological abuse.
4. DESCRIBE typical acts of psychological abuse without physical abuse.
5. DESCRIBE typical acts of physical and psychological neglect.
6. DESCRIBE typical manifestations of physical abuse and neglect in the child.
7. DESCRIBE typical manifestations of psychological abuse and neglect in the child.
8. LIST characteristics of acceptable child-rearing practices today.
9. LIST characteristics of child maltreatment today.
10. COMPARE child maltreatment with acceptable child-rearing practices.

UNIT II. THE NATURE OF CHILD MALTREATMENT

Instructional Objective

The student will be able to distinguish the nature of child maltreatment from acceptable or usual child-rearing practices in society today.

Performance Objectives for Generalization A

1. STATE the federal definition of child maltreatment.
2. IDENTIFY the caretaker.
3. DESCRIBE typical acts of physical and psychological abuse.
4. DESCRIBE typical acts of psychological abuse without physical abuse.
5. DESCRIBE typical acts of physical and psychological neglect.

Generalization A

CHILD MALTREATMENT IS DESCRIBED AS ACTS OF PHYSICAL ABUSE OR NEGLECT AND ACTS OF PSYCHOLOGICAL ABUSE OR NEGLECT ON THE PART OF A CARETAKER.

Sample Content

1. Federal definition of child maltreatment

2. Identity of the caretaker

3. Typical acts of physical and psychological abuse

4. Typical acts of physical and psychological neglect which may result in damage to the child

5. Typical acts of psychological abuse and/or neglect (without physical abuse and/or neglect) which may result in damage to the child

Suggested Classroom Activities and Procedures for Performance Objectives 1 and 2

1. Start with a review of UNIT I. THE PHENOMENON OF CHILD MALTREATMENT, Generalization B Sample Content 1 through 4.
2. Clarify student understanding of the Definition of Terms (II.1).
3. Introduce Generalization II A and write on board for students.
4. Show Definition of Child Maltreatment, Transparency 5, as defined by the Child Abuse Prevention and Treatment Act of 1974. (For further in-depth study of child maltreatment law, see V D.)
5. Discuss what is meant by "the caretaker." Show Identity of the Caretaker, Transparency 6.
6. Explain the identity of the caretaker in terms of III C.
7. Students may:
   - Research and report in class the Maryland State definitions of child abuse and child neglect.
   - Research and report in class the Montgomery County definitions of child abuse and child neglect.
   - Research and write a brief paper on the statistical evidence of child maltreatment in society today.
   - Research and write a brief paper on the sociological evidence of child maltreatment in society today.
8. Conclude with assessment measures for Performance Objectives 1 and 2.

Suggested Classroom Activities and Procedures for Performance Objectives 3, 4, and 5

1. Restate Generalization II A and write on board for students.
2. Clarify the terms "abuse" and "neglect" in terms of "acts of commission" and "acts of omission."
3. Refer students to Definition of Terms (II.1).

4. Show Typical Acts of Physical and Psychological Abuse, Transparency 7.

5. Discuss examples of physical abuse in terms of psychological assault (abuse). Emphasize, on the other hand, that psychological assault (abuse) may exist without physical abuse (assault).

6. Show and discuss Typical Acts of Psychological Abuse Without Physical Abuse, Transparency 8.

7. Review federal, state, and county definitions of child abuse and child neglect. (See V D.)

8. Show and discuss Typical Acts of Physical and Psychological Neglect, Transparency 9.

9. Have students suggest further examples of acts of psychological neglect and discuss possible differences between acts of psychological abuse and acts of psychological neglect on the part of a caretaker.

10. Students may:

    . Read and discuss in class "Defining Emotional Neglect" (V.8).

    . Write a brief summary of selected articles on emotional neglect in the classroom learning center for child maltreatment.

    . Read and discuss selected articles from Violence Against Children (Journal of Clinical Child Psychology) Fall 1973. See classroom learning center for child maltreatment.

    . Write a brief summary of selected articles from the above.

    . Read "Preparing a Neglect Proceeding: A Guide for the Social Worker" (V.9), and discuss the criteria for physical and psychological neglect.

11. Conclude with assessment measures for Performance Objectives 3, 4, and 5.

Instructional Objective

The student will be able to distinguish the nature of child maltreatment from acceptable or usual child-rearing practices in society today.

Performance Objectives for Generalization B

6. DESCRIBE typical manifestations of physical abuse and neglect in the child.
7. DESCRIBE typical manifestations of psychological abuse and neglect in the child.

Generalization B

CHILD MALTREATMENT IS MANIFEST IN PHYSICAL AND PSYCHOLOGICAL DAMAGE IN THE CHILD.

Sample Content

1. Typical manifestations (results) of physical abuse and neglect in the child.
2. Typical manifestations (results) of psychological abuse and neglect in the child

Suggested Classroom Activities and Procedures for Performance Objectives 6 and 7

1. Review briefly I C Sample Content 1, 2, and 3. Analyze selected case histories in terms of dysfunctions within society, the family, and the individual.
2. Review II A Sample Content 1 through 5.
3. Introduce II B, and write on board for students.
4. Explain the spectrum of child maltreatment today as physical/psychological abuse/neglect by the caretaker and physical/psychological abuse/neglect manifestations (effects) in the child.

5. Show Transparency 11 a and b Typical Manifestations of Physical Abuse and Neglect in the Child. (Emphasize NOTE on the transparency.) Discuss examples in terms of radiological and pathological evidence in the child. See I B Sample Content 1.
6. Allow time for student discussion of selected case histories in terms of physical manifestations of abuse and neglect in the child.
7. Show Transparency 12a and b, Typical Manifestations of Psychological Abuse and Neglect in the Child. (Emphasize NOTE on the transparency.) Discuss examples in terms of the "child maltreatment syndrome." See I B Sample Content 1.
8. Allow time for student discussion of selected case histories in terms of psychological manifestations of abuse and neglect in the child.
9. Have students roundtable discuss the relationship of II.8 to II.9.
10. Prepare students in order to minimize any adverse emotional reaction for viewing slides series depicting the maltreated child. See Audiovisual Materials.
11. Students may:
    - Invite a speaker to discuss "the child maltreatment syndrome."
    - View and discuss selected films or slides depicting the maltreated child. (See NOTE for number 10 above.)
    - Write a brief analysis of selected case histories in relation to possible dysfunctions in society, the family, or the individual. (See II. 10 - II. 18.)
    - Draw a diagram to depict the spectrum of child maltreatment.
12. Conclude with assessment measures for Performance Objectives 6 and 7.

UNIT II. THE NATURE OF CHILD MALTREATMENT

Instructional Objective

The student will be able to distinguish the nature of child maltreatment from acceptable or usual child-rearing practices in society today.

Performance Objective for Generalization C

8. LIST characteristics of acceptable child-rearing practices today.
9. LIST the characteristics of child maltreatment today.
10. COMPARE child maltreatment with acceptable child-rearing practices.

Generalization C

CHILD MALTREATMENT IS DISTINGUISHABLE FROM ACCEPTABLE OR USUAL CHILD-REARING PRACTICES IN SOCIETY TODAY.

Sample Content

1. Characteristics of acceptable child-rearing practices today
   - a) Tends to be moderate
   - b) Equal treatment for each child
   - c) Appropriate for the developmental age of the child
   - d) Appropriate for the circumstance
   - e) Concern for the physical and psychological (or emotional) needs of the child
   - f) RESULTS IN THE CHILD'S WELL-BEING
2. Characteristics of child maltreatment today
   - a) Tends to increase in severity and frequency
   - b) Often focusses upon one child at a time
   - c) Inappropriate for the developmental age of the child
   - d) Inappropriate for the circumstances
   - e) Disregards the physical and psychological (or emotional) needs of the child
   - f) RESULTS IN DAMAGE TO THE CHILD

Suggested Classroom Activities and Procedures for Performance Objectives 8, 9, and 10

1. Review briefly I A Sample Content 1 and 2.
2. Have students react to and discuss:
   a) In what way or ways America today is thought of as a child-centered society
   b) How child-rearing practices may differ from place to place; e.g., urban vs. rural areas
   c) How child-rearing practices may differ from family to family
   d) Where child-rearing practices originate
3. Introduce II C Sample Content 1 and write on board.
4. Have a student volunteer write on board characteristics of acceptable or usual child-rearing practices today.
5. Add class suggestions to list.
6. Write II C Sample Content 2 on board. Have students read "Child Care in America" and discuss accepted or current child-rearing practices in relation to custom or tradition.
7. Ask students to compare and contrast the characteristics of child maltreatment with characteristics of acceptable or usual child-rearing practices today.
8. Emphasize the contrasting characteristics: RESULTS IN DAMAGE TO THE CHILD VERSUS RESULTS IN THE CHILD'S WELL-BEING.
9. Students may:
   - Research child-rearing practices in other cultures in relation to child maltreatment and write a paper.

- Invite a resource speaker to talk about acceptable child-rearing practices today.
- Roundtable discuss what is meant by "The maltreatment of children today is rooted in a long history of child abuse and child neglect in society."
- Research current child-rearing practices in America and write a review.

10. Conclude with assessment measures for Performance Objectives 8, 9, and 10.

EVALUATION

for

II. The Nature of Child Maltreatment

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1, 2, 3, 4, AND 5 --
UNIT II. THE NATURE OF CHILD MALTREATMENT

Instructional Objective: The student will be able to distinguish the nature of child maltreatment from acceptable or usual child-rearing practices in society today.

Generalization A Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
1. STATE the definition of child maltreatment.	Define child maltreatment according to the Child Abuse Prevention and Treatment Act of 1974.	II A Sample Content 1 II.1 II.2 I B Transparency 5
2. IDENTIFY the caretaker.	List five possible caretakers.	II A Sample Content 2 II.1 II.3 I B III C Transparency 6

Key Word[1] (See Appendix A.)

STATE - to make a declarative word phrase setting forth something

IDENTIFY - to select from among several choices the item(s) that meet(s) certain criteria

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[1] Thomas Evaul, Behavioral Objectives, Their Rationale and Development (Merchantville, New Jersey: Curriculum and Evaluation Consultants) 1972.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1, 2, 3, 4, AND 5 -- UNIT II. THE NATURE OF CHILD MALTREATMENT

Instructional Objective: The student will be able to distinguish the nature of child maltreatment from acceptable or usual child-rearing practices in society today.

Generalization A Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
3. DESCRIBE typical acts of physical and psychological abuse.	Listed below are acts of child maltreatment. Place a number beside the act which best describes it. (May be answered in more than one way) _____ biting _____ abandoning	II A Sample Content 3 II.1 II.4 II.5 II.6 II.10 through II.18 I B Transparency 7, 8, 9
4. DESCRIBE typical acts of psychological abuse without physical abuse.	_____ actively ignoring _____ dismembering _____ unequal sibling treatment _____ sexually abusing	II A Sample Content 4 See above.
5. DESCRIBE typical acts of physical and psychological neglect.	_____ intermittent or prolonged physical absence _____ failure to provide necessary clothing 1. Physical abuse 2. Psychological abuse 3. Physical neglect 4. Psychological neglect	II A Sample Content 5 See above.

Key Word[2] (See Appendix A.)

DESCRIBE - to state a verbal picture or [to] list the characteristics of a person, place, thing, or event

[2] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 6 AND 7 --
UNIT II. THE NATURE OF CHILD MALTREATMENT

Instructional Objective: The student will be able to distinguish the nature of child maltreatment from acceptable or usual child-rearing practices in society today.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below.
6. DESCRIBE typical manifestations of physical abuse and neglect in the child.	1) State the difference between physical abuse and neglect. 2) Give _____ examples of each as manifestated in the child. 3) Write a brief paragraph on the possible psychological effects (in the child) of physical abuse and neglect.	II B Sample Content 1 II.1 II.8 through II.18 II A I B I C V.8 V.9 Transparency 11 a, b Transparency 12 a, b
7. DESCRIBE typical manifestations of psychological abuse and neglect in the child.	1) State the difference between psychological abuse and psychological neglect. 2) Give _____ examples of psychological abuse and neglect as manifested in the child. 3) Write a brief paragraph on the possible physical effects (in the child) of psychological abuse and neglect.	II B Sample Content 2 II.1 II.8 through II.18 I B I C V.8 V.9 Transparency 11 a, b Transparency 12 a, b Film Cipher in the Snow

Key Word[3] (See Appendix A.)

DESCRIBE - to state a verbal picture or [to] list the characteristics of a person, place, thing, or event

[3] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 8, 9, AND 10 --
UNIT II. THE NATURE OF CHILD MALTREATMENT

Instructional Objective: The student will be able to distinguish the nature of child maltreatment from acceptable or usual child-rearing practices in society today.

Generalization C Performance Objective	Sample Assessment Measures	Criteria for Satisfactory Attainment
The student will: 8. LIST characteristics of acceptable child-rearing practices today.	1) Name _____ ways in which acceptable child-rearing practices differ from child maltreatment today. 2. Give _____ examples of the following characteristics of child-rearing practices today.	The student will give correct information by utilizing the resources listed below: II C Sample Content 1 II.19 I.8 through I.14 I A
9. LIST characteristics of child maltreatment today.	1) Name _____ ways in which maltreatment differs from acceptable child-rearing practices today. 2) Give _____ examples of the following characteristics of child maltreatment today.	II C Sample Content 2 II.19 I.8 through I.14 I A Transparency 7, 8, 9, 10
10. COMPARE child maltreatment with acceptable or usual child-rearing practices today.	In outline form, compare _____ characteristics of child maltreatment with _____ characteristics of acceptable or usual child rearing practices today.	II C Sample Content 1 and 2 See above.

Key Word[4] (See Appendix A.)

LIST - to make a series of words or statements

COMPARE - to list the similarities or differences of things

---

[4] Evaul.

CLASS RECORD FORM

S = SATISFACTORY

UNIT II. THE NATURE OF CHILD MALTREATMENT

U = UNSATISFACTORY

CLASS ______________________________

PERIOD _______________

INSTRUCTIONAL OBJECTIVE: The student will be able to distinguish the nature of child maltreatment from acceptable or usual child-rearing practices in society today.

	PERFORMANCE OBJECTIVE										AVERAGE %	
NAME	1	2	3	4	5	6	7	8	9	10	S	U
AVERAGE % S												
U												

CLASS AVERAGE

GRADE KEY

S----SATISFACTORY for PERFORMANCE OBJECTIVES

U----UNSATISFACTORY for PERFORMANCE OBJECTIVES

60% SATISFACTORY = CREDIT for COURSE

STUDENT ______________________

FINAL GRADE

TOTAL % SATISFACTORY for COURSE _____

TOTAL % UNSATISFACTORY for COURSE _____

INDIVIDUAL STUDENT RECORD

	PERFORMANCE OBJECTIVES																	AVERAGE % Instructional Objectives S	U
UNIT I Instructional Objective	1	2	3	4	5	6	7	8											
UNIT II Instructional Objective	1	2	3	4	5	6	7	8	9	10									
UNIT III Instructional Objective	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
UNIT IV Instructional Objective	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17		
UNIT V Instructional Objective One	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
UNIT V Instructional Objective Two	1	2	3	4	5														
UNIT VI Instructional Objective One	1	2	3	4															
UNIT VI Instructional Objective Two	1	2																	

CLASSROOM INSTRUCTIONAL MATERIALS

for

II. The Nature of Child Maltreatment

SELECTED RESOURCES

1. Definition of Terms (II.1)
2. Federal Definition of Child Maltreatment (II.2)
3. Identity of the Caretaker (II.3)
4. Typical Acts of Physical and Psychological Abuse (II.4)
5. Typical Acts of Psychological Abuse Without Physical Abuse Which May Result in Damage to the Child (II.5)
6. Typical Acts of Physical and Psychological Neglect Which May Result in Damage to the Child (II.6)
7. Characteristics of Child Maltreatment (II.7)
8. Typical Manifestations of Physical Abuse and Neglect in the Child (II.8)
9. Typical Manifestations of Psychological Abuse and Neglect in the Child (II.9)
10. "Signs of Trouble Preceded Death of Boy, 4" (II.10)
11. "Boy Spurned"; "Boys Taken from Home After Beating"; "Infant, 2, Dies, Sitter Is Held"; "Child-beating Death Draws Man Ten Years" (II.11)
12. "Mother admits failure to feed son, who died a 'vegetable' of 8 pounds"; "2 Infants Found in Trash Can"; "Newborn Baby Is Found Left in Trashcan" (II.12)

13. "Beaten, they can't fight back" (II.13)

14. "Mother talks of horror, seeking aid" (II.14)

15. "Law broadened to aid battered" (II.15)

16. "Case History"; "Case History" (II.16)

17. "Don't Shake the Baby" (II.17)

18. "Counter-Culture Kids" (II.18)

19. "Child Care in America" (II.19)

20. "Man's Problem: Learning to Be A Better Parent (II.20)

21. Classroom learning center for child maltreatment

AUDIOVISUAL MATERIAL

Overhead Transparencies

5. Definition of Child Maltreatment

6. Identity of the Caretaker

7. Typical Acts of Physical and Psychological Abuse

8. Typical Acts of Psychological Abuse Without Physical Abuse

9. Typical Acts of Physical and Psychological Neglect

10. Characteristics of Child Maltreatment

11. Typical Manifestations of Physical Abuse and Neglect in the Child (a and b)

12. Typical Manifestations of Psychological Abuse and Neglect in the Child (a and b)

Slides (Series 1 through 10)

A color slide series of photographed examples of child maltreatment is in preparation.

Films

Cipher in the Snow This dramatization of psychological abuse is based on the true story of a boy who no one thought was important until his sudden death one snowy morning. The story on which the film was based won first-place award in the N.E.A. Teachers Writing Contest. Brigham Young University 1973 16mm color 23 min. MCPS Film Library #6571

Growth Failure and Maternal Deprivation This film shows physical and mental retardation in young children which may often result from lack of parental attention, especially from the mother. Two children, one thirteen months old and one almost four years old are shown as examples of failure-to-thrive. The circumstances under which these children lived and those aspects of the mother-child relationship thought to be responsible for their failure to grow and develop normally are discussed.
McGraw Hill 1966 16mm black/white 28 min. MCPS Film Library #4218

THE NATURE OF CHILD MALTREATMENT

*DEFINITION OF TERMS (II.1)

1.	Physical	adj.	- 3: of or relating to the body
2.	Psychological	adj.	- 1: b: MENTAL
3.	Abuse	vt.	- 1: to attack in words 4: to use so as to injure or damage
	Abuse	n.	- 4: abusive language 5: physical maltreatment
4.	Neglect	vt.	- 1: to give little attention or respect to: DISREGARD 2: to leave undone or unattended to especially through carelessness
5.	Damage	n.	- 1: loss or harm resulting from injury to the person SYN: injury
6.	Injure	vt.	- 1a: to inflict bodily harm b: to impair the soundness of
7.	Paramour	n.	- an illicit lover

*_Webster's New Collegiate Dictionary,_ 1974.

(Transparency 5)

THE NATURE OF CHILD MALTREATMENT

*DEFINITION OF CHILD MALTREATMENT (II.2)

The Child Abuse Prevention and Treatment Act of 1974 (P.L. 93--247) defines child abuse and neglect as

> ".....PHYSICAL OR MENTAL INJURY, SEXUAL ABUSE, NEGLIGENT TREATMENT OR MALTREATMENT OF A CHILD UNDER THE AGE OF EIGHTEEN BY A PERSON WHO IS RESPONSIBLE FOR THE CHILD'S WELFARE UNDER CIRCUMSTANCES WHICH INDICATE THAT THE CHILD'S HEALTH OR WELFARE IS HARMED OR THREATENED....."

*DHEW Publication No. (OHD) 74-4, p.1

(Transparency 6)

THE NATURE OF CHILD MALTREATMENT

*IDENTITY OF THE CARETAKER (II.3)

Natural parent

Adoptive parent

Step parent

Foster parent

Sibling

Parent's paramour

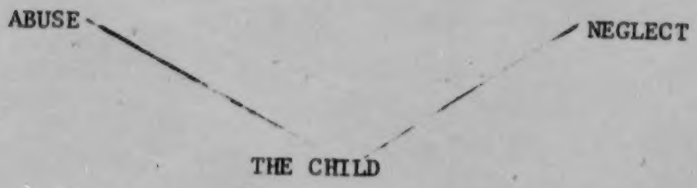
Relative

Babysitter

Staff of institution

Teacher

Other or unknown



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*From the National Standard Form--0023, Children's Division
The American Humane Association, Denver, Colorado
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(Transparency 7)

THE NATURE OF CHILD MALTREATMENT

TYPICAL ACTS OF PHYSICAL AND PSYCHOLOGICAL ABUSE (II.4)

Burning, scalding or branding

Shaking

Biting

Kicking

Beating with hands

Beating with instruments

Exposing to elements

Locking out

Locking in or tying

Poisoning

Shooting

Drowning

Strangling or suffocating

Sexually abusing

Dismembering

Exploiting

Abandoning

(Transparency 8)

THE NATURE OF CHILD MALTREATMENT

TYPICAL ACTS OF PSYCHOLOGICAL ABUSE AND/OR NEGLECT (WITHOUT PHYSICAL ABUSE AND/OR NEGLECT) WHICH MAY RESULT IN DAMAGE TO THE CHILD (II.5)

Unrealistic demands or pressures
Unequal sibling treatment
Consistently negative responses
Threats of extreme physical injury
Threats to withdraw love
Undermining self-esteem
Actively ignoring
Threats to abandon
Others

(Transparency 9)

THE NATURE OF CHILD MALTREATMENT

TYPICAL ACTS OF PHYSICAL AND PSYCHOLOGICAL NEGLECT WHICH MAY RESULT IN DAMAGE TO THE CHILD (II.6)

Failure to provide life-sustaining nutrition

Failure to provide adequate medical care

Failure to provide necessary clothing

Failure to provide minimal shelter

Neglect of educational needs

Inadequate safety precautions

Drug addiction or alcoholism during and after pregnancy

Exposure to immoral conduct

Gross indifference or lack of concern

Absence or withdrawal of love

Intermittent or prolonged physical absence

Unequal sibling treatment

Others

(Transparency 10)

THE NATURE OF CHILD MALTREATMENT

CHARACTERISTICS OF CHILD MALTREATMENT TODAY (II.7)

Tends to increase in severity and frequenty

Often focusses upon one child at a time

Inappropriate for the developmental age of the child

Inappropriate for the occasion or circumstance

Disregards the physical and psychological (emotional) needs of the child

RESULTS IN DAMAGE TO THE CHILD

(Transparency 11 a and b)

THE NATURE OF CHILD MALTREATMENT

*TYPICAL MANIFESTATIONS OF PHYSICAL ABUSE AND NEGLECT IN THE CHILD (II.8)

Abrasions

Contusions

Sprains, dislocations

Malnutrition

Ill kempt

Filthy

Improperly clothed for weather conditions

Growth retardation

Lacerations

Congenital drug addiction

Failure-to-thrive

Whiplash

Evidences of medical neglect

Brain damage

Bone fractures

Internal injuries

Subdural hematoma or hemorrhage

Dismemberment

Absence of clothing

Bruises, burns, welts

*NOTE: Similar manifestations may arise from other causes.

(Transparency 12 a and b)

THE NATURE OF CHILD MALTREATMENT

*TYPICAL MANIFESTATIONS OF PSYCHOLOGICAL ABUSE AND NEGLECT IN THE CHILD (II.9)

Disturbed eating habits, e.g., irregular, too much, too little

Nightmares

Bedwetting, soiling

Extreme passivity

Extreme agressiveness

Antisocial behavior, e.g., stealing, fire-setting, addiction, violence

Apathy or withdrawal

Infantile behavior, e.g., infantile speech, thumbsucking

Stuttering

Loss of speech

Growth retardation

Mental retardation

Academic failure

Temper tantrums

Social retardation

Delayed motor development

Hypersensitivity (auditory and/or visual)

Sadomasochistic behavior

Failure-to-thrive

Abnormal fears

*NOTE: Similar manifestations may arise from other causes.

Signs of Trouble Preceded Death of Boy, 4

By Elizabeth Becker
Washington Post Staff Writer

The week before 4-year-old Shawn Abbey was killed, a school nurse had treated bruises all over his body and strongly suspected that his was a case of child abuse. During that week his mother took an uncommon four-day absence from work. Relatives were barred from Shawn's apartment at gunpoint by his mother's boyfriend and neighbors heard frequent cries and pleadings from a woman and child in that fifth-floor apartment in City Line Towers just across the District line in Suitland.

Nearly everyone associated with them appeared to believe that there was serious trouble between Glenda Abbey, her son Shawn and her boyfriend Michael Leonard but before they could move to help out, the boy was dead. On Friday a bloated body weighed down by concrete blocks was fished out of the Potomac River and identified as Shawn Abbey. His mother, Abbey, 23, and Leonard have been charged with Shawn's murder.

GLENDA ABBEY
..."really well liked"

"You can't begin to understand what Shawn's case has done to us," said Austine Fowler, director of the Anacostia Pre-School program where Shawn was enrolled. "We only knew him for a short time but he was a very articulate child, extremely bright, and he loved school."

A week ago Thursday, Shawn came to school with two black eyes and bruises all over his body after a six-day absence. He "wouldn't let his teacher out of his sight" and clung to her skirts when she escorted him to the health office where a nurse examined him and asked how he had been hurt, Mrs. Fowler said.

"He gave us two or three stories — the nurse couldn't shake the truth from him — and he had to stay out of school because he had two black eyes," Mrs Fowler said. "He wanted to come back. We told the gentleman who picked him up we would follow up the next day but the next morning we got a call that Shawn had a fever and wouldn't be coming in."

SHAWN ABBEY
...found in river

When school officials called the D.C. police youth division on Monday with information on Shawn, they were told to contact the missing person bureau.

See ABBEY, B5, Col.1

On Tuesday, while she was directing the volunteer search around the apartment building at 3901 Suitland Rd., D.C. city councilwoman Willie Hardy was told by neighbors that they had heard cries from a woman and child in the Abbey apartment the week before but no one had reported it to the police.

"Most of them told us of screaming and beatings, even people who had known the family for some time," Mrs. Hardy said. "They also said that the mother had told them of her fear for her boy."

A middle child in a family of twelve, Glenda Abbey met with her sisters often but that last week before Shawn's death she didn't appear when two sisters came to call. Instead, Leonard answered the door and refused to let them in, pointing a gun at one of the sisters, Marcella Richardson, when she tried to come in that last Saturday.

"She tried to leave him...but Glenda Abbey said he tied her down on the bed and sliced her thighs and arms with razor blades," an elder sister, Alvina Moore, said.

A Catholic family that has lived in the District for three generations, the Abbeys say they are a close-knit family that cherishes children. There are 36 grandchildren' and great-grandchildren living in the area. A woman who worked with Glenda Abbey at Washington's United Planning Organization said Miss Abbey took part in many of the family outings at Ft. Washington Park where the family brought buckets of fried chicken, potato salad, cases of soda but no liquor - "liquor was never put down in their mother's house."

"She was really just starting to get it together. She had entirely too much going for her to do something like that," said her brother Jose Abbey. She is a beautiful person...when I was in Vietnam there wasn't one mail call that I didn't receive a letter from her."

Educated in District public schools, Glenda Abbey has been working as a "girl Friday" at UPO for four years. She coordinated fund raising events, including a clothing drive she directed during her free-time, and was named first runner-up in a Miss UPO beauty contest.

"She was very dependable. She'd only be absent if Shawn was sick or she was sick," said Yvonne Better, the coworker. "She was really well-liked...she'd bring in big bowls of potato salad to work...that's why the whole staff showed up at the courthouse" for her bond hearing last week.

Coworkers and the family knew that Glenda was having problems with her boyfriend and for almost two years Shawn had been living with Glenda Abbey's sister, Patheresa Lewis, about the same time period that Glenda had been with Leonard. Five weeks ago the boy moved in with his mother and her boyfriend.

"Glenda always provided for Shawn, she took good care of him and he got on perfectly with his cousins," said Mrs. Lewis. "Normally most k ds have to wait for Christmas for presents but Glenda got h m everything he saw on television. Each year she g ve him a big birthday party w th 40 or 50 children."

It was this affection that her brother Jose believes was a deep problem: "There wa a lot of jealousy involved . . . Glenda was showing too m ch favor to her son and not enough to Mike."

The Washington Post
October 26, 1975
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Permission

Boys Taken From Home AfterBeating

An 8-year-old Prince George's boy and his 6-year-old brother have been removed from their home after the boys were apparently beaten with a belt and extension cord, police reported.

Police said the two Seabrook boys were temporarily placed in foster care after appearing at school with severe slash marks. The older boy had 28 marks and the younger had 50, the police said.

The abrasions were reported to police by the boys' elementary school principal. Under Maryland law, educators, social workers, and health practitioners must report to police any case of suspected child abuse. The law grants immunity from liability to those who report such cases, even if no abuse can be proved.

Private citizens who believe a child is being abused may also tell police or social services about the problem without fear of lawsuit, according to Maryland law.

The Washington Post
April 3, 1976

Boy Spurned

LONDON—Spurned by his mother and stepfather in Israel, a 12-year-old English boy returned to Britain for adoption by an uncle.

Lee Borrett, 12, had plaintively asked, "Why does nobody want me?" when he was left *to fend for* himself after arriving in Israel Sunday to be reunited with his mother, who had remarried there. His father left her before he was born. The boy had been living with his grandmother.

His stepfather, engineer David Bromand, 39, met him at Israel's Lod Airport,

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pushed some money down his shirt and, according to witnesses, said, "I don't want you. I'm not interested in you."

The boy's mother, Angela, said, "He has got to go home. He must go back. My husband will not allow Lee to stay here." The grandmother had paid the one-way ticket to Israel because the boy pined for his mother.

Reprinted by permission of
The Washington Post

The Washington Post, February 23
1976

Infant, 2, Dies, Sitter Is Held

RICHMOND, Feb. 23 (AP)—Tunney Lamont Hanks, 2, who suffered third-degree burns Feb. 14 when he allegedly was placed in a bathtub of scalding water, died Saturday of complications from the injuries, police said Monday.

Police said the child allegedly had been beaten with a belt as punishment for unrolling toilet paper, and then was placed in the hot water after soiling his pants.

The child's mother had left him with a friend, who in turn had left him with a 16-year-old youth for the afternoon, according to police. The 16-year-old baby sitter was charged with felonious assault and released in custody of his parents pending an April 1 hearing in juvenile court.

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The Associated Press

Child-beating death draws man 10 years

A 24-year-old former police cadet and security guard was given a 10-year prison term yesterday for child abuse and second-degree murder in the beating death of his girl friend's 4-year-old son December 20.

William D. Dove 3d, of the 100 block South Catherine street, admitted causing the death of Darryl Richards, of the 300 block McMechen street, whom he was babysitting at the time the boy was beaten with a belt and received an intestinal perforation.

Dove expressed his grief over the death of the victim and said, "If I could give my life in exchange for his, I would do so."

Judge Solomon Liss replied that he was "sorry that can't be arranged." Judge Liss said he did not believe that Dove is vicious but that he is in need of psychiatric treatment.

Neil Steinhorn, the prosecutor, told the court that Dove was babysitting for his girl friend, who works in the main Post Office, at 11.30 P.M. when

See COURT, C2, Col. 1

he discovered that the boy had wet the bed.

The boy was ordered to the bathroom, but became nauseated, and the security guard beat him with the belt causing the intestinal injury, it was stated.

Young Darryl then was put back in bed, but he awoke at about 5 A.M. and was found to be cold and barely breathing, Mr. Steinhorn told the judge. The victim died in the University Hospital.

Dore was a police cadet from 1971 and 1973 and thereafter was employed as a security guard.

THE SUN, Tuesday, May 18, 1976

Reprinted by permission of The Sun (Baltimore, Md.)

THE SUN

Tuesday, May 18, 1976

Mother admits failure to feed son, who died a 'vegetable' of 8 pounds

A 27-year-old mother of four children pleaded guilty yesterday to abusing her 7-month-old son by failing to feed the child, causing his death in April, 1975.

"I failed to give him all the attention I was supposed to because I was drinking and drunk all the time," Cynthia Bernice Pitts, of the 1500 block Argyle avenue, had told police in a signed statement offered into evidence by H. Gary Bass, the prosecutor.

The woman, a convicted prostitute, pleaded guilty to child abuse and manslaughter in the death of Kevin Pitts. She contended the death of the boy's father from overeating crabs and watermelon caused her to become angry and despondent and to neglect the boy.

Her three other children, including twins, are 4 and 5 years old and were fathered by James Walter Pitts, 51, with whom she lived, Mr. Bass said. She also had been dating the father of young Kevin at the same time, Judge Solomon Liss was told.

Judge Liss deferred sentencing pending medical and probation reports.

A medical report submitted to Judge Liss disclosed that when the boy was taken to a hospital he was a "living vegetable" and showed no brain action in a brain-wave test. The infant victim weighed 8 pounds when he died at University Hospital.

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2 Infants Found In Trash Can

LOS ANGELES (AP) — Two abandoned newborn infants were in good condition yesterday as police sought clues to their identities.

The boy and girl, found abandoned 13 hours apart Frixay, were at County-USC Medical Center. A nursing supervisor said both babies were doing well.

Police in Pasadena, where the girl was found in a trash can, and in suburban Downey, where the boy was found in a paper sack on a lawn, said they had no leads on the identifies of the babies.

Reprinted by permission of the Associated Press.

The Washington Star, June 9, 1975

Newborn Baby Is Found Left In Trashcan

BIRMINGHAM, Ala. (UPI) — A newborn baby girl, found abandoned and struggling for breath in a bathroom trash can at a restaurant, was reported doing "absolutely fine" yesterday and police said they had located the mother.

"We know who the mother is," said police Lt. Francis Sartain, head of the Birmingham Youth Aid Division. "She is a 17-year-old girl. She is a juvenile under Alabama law, and we cannot release her name.

"I don't know her marital status, but she probably was not married," Sartain said. "She has been undergoing medical treatment. We don't know why she abandoned the child."

A spokesman at the University of Alabama Hospital said the mother was "in a local hospital, but I am not allowed to say which one."

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The Washington Star, June 30, 1975

Beaten, they can't fight back

The Home News, January 12, 1976

By JOAN HRITZ
Home News staff writer

NEW BRUNSWICK — "Abusive parents are not necessarily monsters. They have a need for understanding, compassion, sympathy and help."

Doctors and nurses attending the Protective Services Resource Institute at St. Peter's Medical Center were asked by Dr. Christian M. Hansen to keep that statement in mind as he talked about the victims of child abuse and neglect.

Dr. Hansen, a member of the pediatrics department of Rutgers Medical School, discussed the health and psychosocial aspects of child abuse.

He said that when an abusive parent brings a child to the hospital for aid, it can mean that "the parents are subsequently asking for help."

He referred to the natural repugnance nurses and doctors feel when they confront an abusive parent, but reminded them that the parents may, themselves, have been abused as children.

"The battered child often becomes the battering parent of the next generation," he said of this truly vicious cycle.

The cycle is known officially as The World of Abnormal Rearing (W.A.R.). Children who are abused or neglected find themselves being reared in this unusual atmosphere.

The parents have unrealistic expectations of their children, who cannot possibly meet the needs of these troubled adults. The children are constantly being punished for this. Often present is a reversal of roles, with the parent expecting the child to take over his or her role.

The parents display a lack of trust and have a feeling of isolation. They feel they are no good to anyone and cannot help others. Their children are denied a true childhood.

The children, in turn, leave home and are often anxious to have youngsters of their own. Once they have babies, the whole cycle begins again, with the infant expected to meet the type of demands and expectations their parents contended with when they were young.

The abusive parents "expect too much of the child too soon," Dr. Hansen said.

So, although the primary purpose of the institute is to help the abused or neglected child, it also aims to help the parents through a variety of professional agencies. The goal is rehabilitation of the parents.

It has been estimated that only 10 per cent of abusive parents are psychotic or otherwise seriously ill psychiatrically, he added.

Neglected children may display a variety of symptoms, including gross motor and psychological retardation and problems in language and personal and social skills.

"They may be slow to speak," Dr. Hansen said, pointing out that the children really are emotionally deprived rather than retarded.

They tend to engage in repetitive play, do not explore and "turn into themselves." They may be sober and irritable as a rule.

These children cling to their parents or caretakers, but have little eye contact with them. They may be demanding and have temper tantrums.

Abused or battered children may sustain damage to their central motor or nervous system. "As many as 35 per cent may show physical impairment," Dr. Hansen noted. They often have learning problems in school.

He referred to the "shaken infant syndrome." In this, parents of young children shake them vigorously and often, with the possible result of bleeding under the skull even though the infants are not thrown or beaten.

Abused children are brought to hospital emergency rooms with broken bones in their arms and legs, brain damage and skin injury through burns. Suspicious bone injuries can be diagnosed in the hospital by a skeletal survey.

The parents in these cases cannot satisfactorily explain how the injury occurred to the emergency room personnel.

Dr. Hansen told of the case, in another area, of a two-year-old sent home after his fractured arm was set.

Several months later, the abused child was dead on arrival at the hospital.

Similar incidents are "happening all too often," Dr. Hansen said.

He added that "225 kids will probably die in New Jersey in 1975 as the result of physical battering." Many more will have been injured, he noted.

Dr. Hansen accompanied his discussion with color slides showing severe injuries to infants and young children.

One displayed cigarette burns by which the parents said they "disciplined" their youngster.

Another child had second and third degree burns on the lower half of his body. His parents said the badly scalded child had stepped in a tub of hot water, but the fact that his feet were clear of burns told the hospital staff this was untrue.

One child had lash marks about the face and body, made by a rope or coat hanger. Here, the parents said playmates had beaten the youngster.

Another had been severely beaten with a strap or belt. Some parents "feel they have a constitutional right" to discipline by beating, the doctor added.

An 18-month-old boy, starved as a punishment, closely resembled the victims photographed in Nazi concentral camps. Three weeks later, after receiving proper nutrition, he looked like another person.

However, he may already have sustained the brain damage caused by lack of proper feeding, the doctor said.

Ten per cent of children brought into emergency rooms may have been abused, he said. "A healthy index of suspicion is necessary" on the part of hospital personnel, Dr. Hansen declared.

He pointed out that the abusing parent often "hospital shops." To combat this, the Division of Youth and Family Services is setting up a central registry by which repeated incidents of a child being injured can be checked for suspected child abuse.

Increased unemployment, with its added tensions and fathers at home more has resulted in increased cases of child battering.

Battered children are the least able to defend themselves. Fully 80 per cent of them are under the age of three years.

Several physicians and nurses attending the institute said there were a number of problems involved in designating a child as an abused youngster.

One was not being able to follow up care of the child as the case is handled by other medical personnel on other shifts at the hospital. A doctor commented that some private physicians are reluctant to corroborate suspected abuse cases.

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NEW BRUNSWICK N.J. TUESDAY JANUARY [illegible] Home News 5

Child abuse

Mother talks of horror, seeking aid

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EDITOR'S NOTE: Second in a four-part series on the subject of child abuse. Today's installment is one woman's story on the way she felt when she abused her own child and how she sought help.

By JOAN HRITZ
Home News staff writer

NEW BRUNSWICK — Lee is 27 years old.

She is tall, with medium-length dark brown hair and brown eyes. She is very attractive and vivacious.

The mother of three younsters, she speaks articulately and seems quite intelligent.

Lee also has been a child abuser.

She never reached the stage of fracturing a child's arm or leg or inflicting cigarette burns, but, Lee says, she was headed that way.

She credits a self-help organization known as Parents Anonymous with saving her situation.

Her short-term experience with child abuse started several years ago. She, her husband and their three children had moved to Baltimore.

Within a short period of time "the roof fell in" on her emotionally.

Her father was dying, her husband had lost his job and was starting his own business and her sister was getting a divorce and leaning on Lee a lot.

"I had no time for my children's problems," she says. Whenever they'd come to her, she'd scream "leave me alone." The children lost self-confidence.

She had come from a rigid, authoritarian background, with a stern, disciplinarian father. When she tried to tell her mother about her problems, the answer was "I didn't tell you to have children."

Lee's hostility was directed mainly against her oldest child, a boy with what she described as a "negative personality."

At the age of 18, she had become pregnant with him before marrying his father. It was a difficult birth and Lee was in labor for 46 hours. She also recalls being "up 42 hours with a six-day-old colicky baby."

The child was about four when the move to Baltimore and the trouble occurred. Lee grew increasingly tense.

She remembers envying a neighbor who seemed to be able to "handle evrything," including home and children, without getting rattled.

Lee began abusing the boy verbally and physically and to set up situations in which the child would "earn" punishment. "I wanted to throw him down the stairs," she says. On one occasion, a blow from her "heaved him half way across the room."

The culmination seemed to come one day when she had to take the children to their pediatrician. In a fit of anger "I had slapped him across the face and my handprint showed," she says.

At the doctor's office, she waited for him to say something about the mark, but "he never said a word." Lee feels she wanted him to do so, because she knew she needed help.

She notes that many pediatricians are reluctant to mention similar incidents for fear of damaging their relationship with the parents.

Of this low point in her life, Lee says "I stopped when I got scared." She feared that, in another few months she might have beaten the boy severely if she had not found help.

That help came from a nearby group called Parents Anonymous, which helps parents to "keep their cool." These groups can be found in many parts of the country.

For the first time, someone listened to her, sympathetically. "Before I knew it, I was spilling my guts out," crying that "I can't cope. I hate the kids," she says.

Her group had started with six or seven women facing similar problems.

Lee had felt terribly isolated. She received no bolstering from her family and didn't want to bother her husband, who was facing the problem of earning a living for the family. Fortunately for her, the marriage is a good one, she says.

At PA, as the group is known, she began to feel she wasn't the only one who ever hit a child and she stopped feeling so isolated.

She speaks of the variety of people in her PA group, which included "one extremely rich family and an extremely poor one."

There was one parent with a master's degree and another who only had gone as far as the sixth grade.

The problem, she points out, has no educational, economic or racial boundaries. It cuts across all of them.

Lee felt she now had a place to turn to with her problems and it was the start of improvement for her. Although her relationship with her oldest child isn't ideal, she now is able to handle the problems in a calmer fashion and to bring a greater degree of understanding to that relationship, she says.

She believes that abusive parents want help, but some won't come to PA meetings because they fear the children will be taken away from them by the authorities. Those who "hospital shop" are looking for help, she adds.

Of the line that divides abuse from discipline, she feels that "when it's over and beyond discipline," it's abuse. She was angry at everything else and wanted to take it out on her oldest boy.

If physical discipline is constant and repeated and children are "set up" to receive punishment, it's abuse, she declared.

Basically, she loves the children and had experienced much guilt over her actions. She thinks that "as long as you have guilt you can be helped." Sometimes she wanted to hurt them "but I always had that guilt afterwards," she adds.

There also are parents who are "verbally abusing," and show no affection for the child, she notes.

Lee feels her experience with PA worked for her as it has for others.

And, she ought to know.

As Lee says, "I've been there."

Child abuse

The Home News
January 15, 1976

Law broadened to aid battered

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Last in a series of articles on child abuse. Today's installment deals with the legalities involved in protecting the children.

By JOAN HRITZ
Home News staff writer

NEW BRUNSWICK — New Jersey's concern for abused or neglected children dates back to the 19th century, but this concern was translated into action in more recent legislation broadening the scope of methods of protecting children.

The legal aspects and the role of the Division of Youth and Family Services (DYFS) of the state Department of Institutions and Agencies were outlined by Evelyn Strawn, consultant trainer of the Protective Services Resource Institute.

Services available in Middlesex County were discussed by Mrs. Jane Wierich, assistant supervisor of the Protective Services Unit of DYFS in Middlesex County. The area office is at 78 Carroll Place.

Miss Straum said the newest child abuse and neglect statute, which became effective last January, expanded protection by broadening the authority for removing a child from a dangerous or potentially dangerous environment. It also increased provisions to insure effective reporting and handling of suspected incidents.

The law is implemented by the DYFS, which also tries to help troubled families in which children are abused or neglected, through a variety of agencies. The emphasis is on helping parents as well as children.

It expands the authority for removing a child from an abusive or neglectful environment in three major ways: by removal with consent of the parents, in which a child may be removed if a complaint is filed in Juvenile and Domestic Relations Court within three court days;

Removal without parental consent, but with a court order, providing a formal complaint is filed within thr3e days unless the child is returned home sooner;

Removal without parental consent and without a court order, by a police or peace officer or employe of the county probation department or the DYFS, providing a complaint is filed by the removing party in Juvenile Court no later than the next court day after removal.

The law mandates free legal representation for the children by attorneys from the state office of the Public Defender, Department of the Public Advocate.

Reporting of suspected incidents is streamlined and made uniform under the law. Any person suspecting abuse or neglect is required to report it directly to the DYFS, Previously, physicians were required to report serious incidents of suspected abuse to the county prosecutor.

The change in procedure is aimed at insuring that all suspected incidents, regardless of who reports them, are brought to the attention of the division for appropriate follow-up action.

The law outlines the type of evidence that is admissible and states that "the privilege of confidential communications between husband-wife, physician-patient and social worker-client is not grounds for excluding any evidence in a court hearing."

If the court sustains a complaint of neglect or abuse, it may elect either to return the child to the home, with certain restrictions and conditions imposed upon the parent or guardian for the child's welfare, or to order the child placed in substitute care temporarily, out of the home.

An out-of-home placement order may be issued for 18 months, with successive extensions for one-year periods, after a court hearing. The court also may order a child placed with a relative or other suitable person or refer a child to the DYFS for placement.

The court also may order the parent or guardian to seek or accept therapeutic services and professional therapy. If the person is unable to pay for these services, the state will.

Anyone reporting an incident is immune from civil or criminal liability and any person failing to report a suspected incident to the DYFS may be charged as a disorderly person.

Under the law, an abused or neglected child is defined as one under 18 years of age whose parent or guardian inflicts or allows physical injury of the child and as one who shows physical, mental or emotional conditions impaired through lack of care and supervision. The child also could be one, against whom a sex act has been committed by the person responsible for him or one who has been willfully abandoned by parent or guardian.

The procedure for reporting was explained by Miss Straum. All incidents of suspected child abuse or neglect must be reported immediately to the DYFS, regardless of whether any attempt is being made to remove the child.

If the incident occurs outside of regular 9 a.m. to 5 p.m. hours, it should be reported to the division's Office of Child Abuse Control, which provides a 24-hour emergency hotline for reporting such incidents. The toll-free number is Area Code 800 792-8610.

For a reported incident, the information needed includes the name of the child, address and telephone number of the family, a description of the youngster's condition and the child's whereabouts.

The person reporting the incident may remain anonymous.

Middlesex County's office is located at 78 Carroll Place and the telephone number is 249-4616.

Mrs. Wierich stressed the need "to nurture the parent, to help parents like themselves."

She added that abusive and neglectful parents are "isolated and overwhelmed with good reason. Many clients don't know they can get help. They see themselves as failures."

She noted that reporting of suspected abuse cases is up in the county and state and mentioned the local parents unit to aid parents with problems through intensive weekly therapy sessions. If they do not have transportation to such sessions it can be provided. Homemaker services and a variety of others also are available.

She said there are less referrals in the summer and recalled that the local caseload went up threefold durings the gasoline shortage of 1974

NEW BRUNSWICK, N.J., TUESDAY, JANUARY 13, 1976 5

Case history

Karen J. was a two-year-old who was referred by an orthopedist for an evaluation of multiple fractures of both legs. These were said by the mother to be the result of the child's crib falling to the ground three times at home.

It was apparent that the referring physician never suspected willful battering by the parents. X-rays revealed old, healing fractures of other bones and the radiologist made a definite statement to the effect that these findings were the results of multiple trauma.

The social worker stated that the mother denied abuse on her own and her husband's part and admitted that she felt people suspected her of harming the child.

She became very angry when she was asked to talk about how she thought the injury had occurred. She seemed to be overwhelmed by the situation.

Both parents were young, 21, and the mother pregnant at the time. The mother had run away from home when she was 14, became pregnant and married a Mr. J., whom she left two years ago because of his heavy drinking and general irresponsibility.

Then she met her present husband, who was seperated from his wife after nine years of marriage. She then became pregnant and married her present husband one month after the baby's birth.

The mother attributed their problems to not having enough money, especially since they were expecting a new baby.

At the same time, there were some positive signs in that the parents seemed cooperative and truly concerned about the welfare of their child.

At discharge, the judge gave temporary custody to a grandmother and allowed the parents to have the child back after a period of time.

At a later time, the parents appeared to be better able to manage their problems, with fewer tensions than in the early years of the marriage.

Case history

Barbara L. was a three-month-old who was hospitalized because of seizures. She was said to have been found by her parents, twitching at home after a feeding.

Examination showed a comatose infant with large bruises on her legs and signs of increased intracranial pressure. X-rays revealed old fractures to such a degree that the medical staff felt that they could not have been caused by a fall from a short height.

The parents gave three differing histories of how the injuries occurred, none of which could account for the severity of the clinical picture.

Further history revealed that the parents had adopted this infant and that the mother had been under psychiatric care at the time. This fact had not been mentioned by any of her references. The parents were described as being a nice young couple.

The adoption had been disputed by the physician who delivered the baby, but it was felt that investigation of the new parents was not careful enough by the adoption agency.

The infant finally was discharged, but in a poor state — unable to move her legs because of permanent injury to the spinal cord. The judge gave custody to the State, which arranged to place the child with someone, but this did not occur.

Finally, the infant was hospitalized in another place, where she died.

The mother was committed to a state hospital. Later, the father admitted his wife had "done something" to the infant, but that he did not know what she was doing at the time.

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Home News

Case history

Valerie D. was a three-year-old who was admitted to a hospital with a three-day history of diarrhea. She was in a coma, dehydrated and covered with cuts. In addition, her right ear was almost cut through.

However, she eventually recovered.

Social history revealed she had been referred to an agency two weeks before her admission by an aunt who complained the mother had hit the child with high-heeled shoes and other hard objects.

The hospital social worker interviewed the mother and felt the latter's response was inadequate in explanation of the injuries.

The child had not been planned and the mother was quite ill during the pregnancy. She had hoped for a boy and was disappointed it was a girl. There had been financial problems when the father was laid off from his job. The parents had been married when the baby was two months old.

Early in the girl's life, the mother showed abnormal signs in her treatment of the child.

She attempted to toilet train her when she was six months old and to get her to walk before she was ready by hitting the child across the knees.

The mother felt the girl was "stubborn." The father told the social worker the mother disliked the child and lost patience with her easily. The parents had many arguments about the child.

Valerie had been hospitalized twice at a city hospital. The first time at six weeks of age for convulsions and malnutrition. The second occurred a short time later for meningitis, from which she recovered with some residual problems.

She was discharged in the care of her parents, but the case was followed actively by an agency.

Don't Shake the Baby

At the sight of a new baby, some well-meaning adults seem to feel an irresistible urge to pick up the infant and jiggle it, or even toss it in the air. As a toddler, the same child may be shaken vigorously by the shoulders when his parents are angry with him. These common practices can be quite dangerous, a Pittsburgh pediatrician cautions: in fact, shaking a baby younger than 2 years old may cause severe brain damage—or even death.

A young child's head, explains Dr. John Caffey, is relatively heavy, and his neck muscles are weak. Under the stress of being tossed in play or shaken in anger, the baby's head flops about freely, creating a high risk of massive bleeding from the blood vessels that supply the brain. Such bleeding can result in a subdural hematoma, a condition in which membranes form around the brain and prevent it from growing. With early diagnosis, says Caffey, who is professor of radiology at the University of Pittsburgh as well as a pediatrician, the membranes can be surgically removed before the brain has been damaged. But in the case of babies who have been shaken, such a diagnosis is difficult to make since—unlike the so-called "battered" child—they do not bear any external signs of mistreatment and are unlikely to be brought to a hospital at all.

Phenomenon: The frequency of brain damage from bouncing or shaking children is not known, says Caffey, but enough clear-cut cases have been documented in the past to warrant a major study of the phenomenon. During the 1940s, for example, a notorious private baby nurse in New Haven, Conn., confessed to shaking two of her charges to death, and autopsies of the infants showed that they had indeed died of brain hemorrhaging. Dozens of other babies cared for by the same woman grew up to be mentally retarded—and she admitted to having shaken them too.

Tony Rollo—Newsweek

Child's play: Handle with care

The shaking need not be severe to cause harm, cautions Caffey. Shaking a child moderately by the shoulders a couple of times a week, he says, can have a cumulative effect equivalent to that of a single whiplash injury for an adult—but with much more serious consequences for the child's developing brain. "Many slow-learning and clumsy children with IQ's of 90," Caffey speculates, "might have been intelligent and normally mobile children with IQ's of 120, had they not been habitually shaken and whiplashed during infancy."

Playing with babies and little children, Caffey emphasizes, should always be done gently, with care to avoid jiggling or jerking the child's head. When lifting or handling an infant, it is always best to cradle its head in one's hand or arm. Similarly, toddlers should not be held upside down by the ankles and swung around, no matter how they seem to enjoy it. And, says Caffey, no child should ever be shaken by the shoulders or slapped on the head as punishment.

Newsweek, December 9, 1974

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LIFE/STYLE

Counter-Culture Kids

For the defiant young dropouts of the 1960s, the worst possible fate was to grow up to be like their parents. They believed their own problems, and those of the world, to have been caused by a Depression generation that valued financial security to the exclusion of human sensibilities. And they vowed they would—and could—do better with their own offspring in their own counter-culture. In "The Children of the Counterculture," authors Susan Wolf and John Rothchild recount their tour of the nation's communes to find if the liberated life-style of the communards has created better, happier children.

What they found is that "there is no such thing as a free child." The "love" culture, they report, is afflicted by the same familial terrors and failings that exist in conventional families. While the suburban mother may drink gin to forget the annoyances of a child, the free-school mother pops LSD. Shipping a child off to boarding school and leaving one to run wild in a commune pack can both indicate that a parent doesn't want to be bothered. The authors found some points to praise. Most communal parents and children deal with each other in a straightforward manner with some good results: "We saw no skirt-clutchers or thumb-suckers, no leg-biters or couch-hiders." But while many counter-culture children are remarkably self-reliant, the authors found that most are illiterate, many are ignored and the majority are pitifully unprepared for life outside the commune.

From regimented religious communes to acid-soaked crash pads, the children of the flower children emerge less as human beings than as experiments in radical philosophy. There are brats like Ernesto, a Weathercouple son, who threw tantrums while his mother tried to calm him with rhetoric but refused to discipline him. There are disturbed children like 10-year-old Ben, whose mother seduced him at 6 so he "could win" the Oedipal struggle. Unwashed Noah, 5, already knew the list of commune diseases—"strep, hep, syph and clap." Andy Peyote, a remarkably resourceful 12-year-old, took his saved-up earnings to pay for a mind-control course. Ten-year-old Nina, living in a barren Miami nightmare of acid freaks, created her own bourgeois world with teddy bears, hairbrushes and a neat gingham bedspread. "If you want to have a straight kid, then be a freaky mother," her mother sighed.

Trek: Wolf, a documentary film editor, and Rothchild, a magazine editor, met at the 1972 Republican National Convention in Miami. "We had a lot of friends who had been part of the anti-Establishment movement," says the 30-year-old Rothchild. "We got to talking and decided that no one had looked at the children and what was happening to them." Armed with a book contract and a van loaded with life's necessities, including Wolf's son Chauncey, 5, and daughter Bernsie, 3, they began an eight-month trek into the corners of counter-culture life. "We didn't know what we hoped to find," says Wolf, 37. "We went as critics."

Chauncey and Bernsie, it turned out, were useful foils for the children they met. One thing the authors discovered was that kids will be kids however they are brought up. From the undisciplined Free School in Miami to the regimented "Farm" in Tennessee, Wolf's children and the commune children shared games and fought over toys, TV and apple pie.

Commune children: Illiterate, ignored, unprepared

Jill Henry

But the commune kids differed from Chauncey and Bernsie in their remarkable lack of education. With the exception of Synanon, the strict therapeutic community in northern California, the communes left kids free to learn or not learn. Most chose the latter. The children were being prepared "not to get into college, but feel good," says Rothchild. Even so, he found that the "children of rural communes were not basket cases. Intellectual life was nonexistent there, but for them there are other ways to live." Still, Wolf and Rothchild wonder whether these children will ever be able to enter the mainstream of American life—if indeed they ever want to.

Their travels made the authors examine their goals as parents. "I'm much tougher," says Rothchild. Wolf, impressed by the self-reliance of many of the commune kids, says she "learned to ask more from my children than I thought I could have." Yet the couple decided that tribal living was not for them. "Commune parents wanted a kind of emotional goodness for their children which they gave them at the cost of the self-centered drive that leads to personal achievement," they concluded. "We couldn't see famous writers or scientists coming out of that generation of ragamuffins. We still had that self-centered drive, that urge for private fantasy and mental exercise." Liberation, in short, can be a very confining experience.

—MARY ALICE KELLOGG

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CHILD DEVELOPMENT

From Swaddling Cloth to Dr. Spock:

CHILD CARE IN AMERICA

The first generation of colonial children were not mirror images of the relatives they left behind in Europe. Perhaps it was the pioneer spirit or the brisk climate that made the difference, for they were slightly harder to handle and more rebellious, according to their parents' accounts.

THE REVOLUTIONARY ERA

The Puritan ethic determined the child rearing methods of 17th-century America. Father was the supreme ruler, with corresponding power vested in him. Mother's role was to bear, clothe, feed, and coddle the infant. After the baby was thusly "spoiled," it was Father's turn to take over and correct this indulgence. For in the Puritan view, a child was bad by nature and had to be "saved."

During colonial days, children were depicted as miniature adults, differing from their parents "only in respect to size, experience, and capabilities," according to Mary Cable, author of *The Little Darlings.** The young ones were dressed, doctored, and fed just like the adults. And with standards of hygiene as they were, it's not surprising that many babies died early.

Since the original colonists came in search of religious freedom, the church played a strong role in a child's upbringing. Pious behavior was amply rewarded by God and parents. As was inevitable, many colonial kids rebelled against this extreme religious fervor, and the first American generation gap came into being!

After 1776, patriotism became as important as religion in guiding children. Little ones were brought up to be righteous citizens, proud of their free country. Although the Bible was still the major reading matter, alphabet and story books began appearing. The only authoritative source on child care was John Locke's *Some Thoughts Concerning Education,* a handbook on feeding, toilet training, bathing, and so forth. Locke tried to combat the practice of keeping babies swaddled and airless by advocating open windows and cold baths.

THE NINETEENTH CENTURY

George Washington became the deity for children to worship and imitate at the beginning of the 19th century. Mothers tried to pattern their techniques after Mrs. Washington's with young George, complete with the details of a "fireside education."

Discipline was administered strictly by use of the birch or hickory rod. Robert E. Lee's aunt, who was largely responsible for his upbringing, verifies this by summing up her child care philosophy as "whip and pray and pray and whip." Unfortunately, several reports of severe child abuse also appeared at this time.

Although child care was fairly uniform throughout the country, the richer children of the South were brought up according to plantation protocol. Little girls were stereotyped to become Southern belles, and little boys, chivalrous gentlemen. Victorian mores were practiced throughout, and sex was neither thought nor taught. The social graces and "delicacy" were diligently learned.

During the second half of the 19th century, more and more expert advice was being written on child care. Books and magazines were aimed at mothers, for they were again the major influence on development. This was largely due to the industrial revolution, which pulled many city fathers away from home.

In her book, Mary Cable attributes industrialization, combined with a movement to the cities, the rising middle class, the new frontier of the West, and the decline of Puritan thinking, to a change in the value system. A more permissive attitude toward children was one of the new values that emerged. Although the whip was still used, it happened less frequently, and only after a child had unconditionally refused to obey. Toward the turn of the century, children began to assert themselves more.

THE TWENTIETH CENTURY

Science was beginning to be applied to child care, replacing religion and patriotism. Nutrition, exercise, and medical advances were producing healthier children. And the father was once again assuming his place in child rearing.

With the advent of scientific thinking came several experts to theorize about child development. Dr. John B. Watson, a behavioral psychologist, believed that children could be trained like animals by "conditioned reflex," and thus behave in certain obedient ways. Many parents used Watson's techniques to toilet train, feed, and teach chores to their children. A minimum of open affection went along with this philosophy.

In the mid-1930's, the rigidity of Watson's thinking was replaced by more democratic beliefs. Publications, parent associations, and pediatricians were prolific — most embracing a more permissive attitude.

The most important child care manual to come out of this century was Dr. Benjamin Spock's *Baby and Child Care* — the parents' bible since its publication in 1946. Dr. Spock outlined methods for the physical, emotional, and social upbringing of the modern child. This famous baby expert suggested a gentle but firm hand, rather than total permissiveness, to instill responsibility.

The second half of this century fostered many new child care theories from psychologists, sociologists, child care laboratories, and even the government. But though children today have many more rights and comforts, they still share some of the same gripes and problems faced by their colonial ancestors.—P.C.

**A History of Child Rearing in America;* Charles Scribner's Sons, New York, 1975.

Photographs courtesy of the New York Public Library

Man's Problem: Learning to Be A Better Parent

By Thomas Grubisich

Washington Post Staff Writer

EQUIPPED WITH a bigger brain, man has frequently outsmarted creatures beneath him on the evolutionary scale. But not always.

Take, for example, being a parent. Compared with his inferiors in the animal world, say, the monkey, chimpanzee or elephant, man makes a poor parent. And not just contemporary man, the befuddled target of lecturing grandparents and patronizing how-to-be-a-better-parent books.

According to Dr. Dan Leviton, professor of health education at the University of Maryland, people weren't better parents 30 years ago, or 100 years ago, and certainly not centuries earlier. There is ample evidence, he said, to show that in the past they were worse parents.

"If you look back in history," Leviton said in an interview at his College Park office, "you'll find that sexual abuse of children was par for the course. Children were forced to work. If you wanted to get rid of children, you let them die. This was especially true of infants who happened to be female," potential child bearers.

When the child hasn't been a competitor for meager food (the starting point for "Hansel and Gretel"), he has been an interloper competing for affections his parents show for each other (a theme as ancient as Sophocles and as recent as Freud).

Leviton cited a recent anthology of 10 psychohistorians, "The History of Childhood," which surveys the way parents have treated their children from ancient time through the 19th century.

In the opening chapter, Lloyd deMause, editor of the book, cites the often innocently portrayed practice of swaddling. A child was tightly bound, deMause said, so he "couldn't tear its eyes out, break its legs or touch its genitals."

There was also the matter of parental convenience. Historical sources, he said, described swaddled children "as being laid for hours behind the hot oven, hung on pegs on the wall, placed in tubs, and in general, 'left, like a parcel, in every convenient corner' " (quoting a 19th century study).

DeMause also mentions the frequent practice of terrorizing children with stories, many legitimized into classics, where their peers were eaten raw, torn to pieces, held over the pit of hell and had the blood sucked from the marrow of their bones, presumably to make them "less rash and ungovernable" (quoting the ancient writer Dio Chrysostom).

Why has man so often been a poor parent?

Leviton thinks so because man, while frequently the master of his environment, is also susceptible to strains and pressures that are of no concern to nonthinking animals. These strains and pressures, along with superstitions, fanatical religious beliefs and cockeyed ideas of health, all have been projected onto children, the most convenient of targets, he said.

Leviton, who last year introduced a course on death, thinks it's time that child rearing be studied as a science, as a part of health education, which is what he teaches at College Park. He has proposed a course for next fall that would be called "Parenting Toward Peace and Love."

When he first presented the proposal, some academic officials balked. They didn't like the title. "They considered it too much like 'apple pie and motherhood,' " Leviton said. "If I had substituted it with something like 'toward the reduction of aggression,' I was told, that would be better."

But Leviton said he chose the words peace and love deliberately because he feels that while there has been voluminous study into aggression and abuse, there has been little research into the positive aspects of child rearing.

The course would emphasize the importance of body contact between parent and child because "skin contact transmits love, it tells the child he's worthwhile."

Leviton sees potential problems in the increasing reliance on day-care center when both parents work. Too often, he said, chilren are kept busy with crayons and paper and other activities that don't involve contact between the child and teacher who is the substitute parent.

Unabashedly stressing peace and love, Leviton said he doesn't doubt his course "will be viewed as grandiose, perhaps even crackpot, since the determinist's argument is that man will always make war."

Leviton said his course will not be an exercise in "touchy-feely." "I'm not interested in sitting around in an encounter group, studying the fluctuations of the navel."

Students in the course, he said, would be given some history of child rearing. They would visit children's clinics and day-care centers that stress contact and those that don't.

Leviton would also like to have his students visit the homes of some families that can serve as a model.

Peace and love were the bywords of the flower generation of youth of the 1960s.

While in some contemporary interpretations of the period the flowers have turned to dust, Leviton thinks some seeds took hold and have bloomed, but in different shapes and colors.

"I believe what that generation started has lived on," he said. "Many so-called straight people today are acting as the hippies did years ago. There is a live-and-let live attitude. People are thinking twice about war. They seem to be saying, 'We want a new day.' "

II. THE NATURE OF CHILD MALTREATMENT (II.20)
The Washington Post, January 30, 1975
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UNIT III

The Episode of Child Maltreatment

III. THE EPISODE OF CHILD MALTREATMENT

--- Who Does It?

UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective for Unit III

THE STUDENT WILL BE ABLE TO DESCRIBE THE COMPONENTS IN AN EPISODE OF CHILD MALTREATMENT.

Generalizations for Unit III

A. The episode of child maltreatment is attributed to a potentially abusive or neglectful caretaker, to a potentially vulnerable child, and to stress as the "triggering" mechanism.

B. The episode of child maltreatment may also include a passive partner and/or sibling on-looker(s).

C. The potentially abusive or neglectful caretaker is representative of a cross-section of any community in terms of race and/or social or economic status.

D. The potentially vulnerable child may be an exceptional or demanding child or a normal one.

E. Stress, the "triggering" mechanism, may originate within society, the family, or the individual.

Performance Objectives for Unit III

1. LIST the components of the episode of child maltreatment.
2. EXPLAIN the role of the caretaker.
3. EXPLAIN the role of the child.
4. EXPLAIN the role of stress.
5. EXPLAIN the role of the passive partner.
6. EXPLAIN the role of the sibling on-looker(s).

7. IDENTIFY the potentially abusive or neglectful caretaker.
8. STATE the characteristics of the potentially abusive or neglectful caretaker.
9. IDENTIFY the potentially vulnerable child.
10. STATE the characteristics of the potentially vulnerable child.
11. DESCRIBE the potentially vulnerable child from the viewpoint of the caretaker.
12. STATE the meaning of the term "stress" in relation to time (duration).
13. LIST the characteristics of stress.
14. CLASSIFY the kinds of stress.
15. DESCRIBE the origins of stress.

UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective

The student will be able to describe the components in an episode of child maltreatment.

Performance Objectives for Generalization A and B

1. LIST the components in the episode of child maltreatment.
2. EXPLAIN the role of the caretaker.
3. EXPLAIN the role of the child.
4. EXPLAIN the role of stress.
5. EXPLAIN the role of the passive partner.
6. EXPLAIN the role of sibling on-looker(s)

Generalizations A and B

THE EPISODE OF CHILD MALTREATMENT IS ATTRIBUTED TO A POTENTIALLY ABUSIVE OR NEGLECTFUL CARETAKER, TO A POTENTIALLY VULNERABLE CHILD, AND TO STRESS AS THE "TRIGGERING" MECHANISM.

THE EPISODE MAY ALSO INCLUDE A PASSIVE PARTNER AND SIBLING ON-LOOKER(S).

Sample Content

1. The role of the potentially abusive or neglectful caretaker
    - a) Every individual is a potentially abusive or neglectful caretaker. (See I B Sample Content 4)
    - b) Individuals differ in their potential. (See I C)

2. The role of the potentially vulnerable child
    - a) All children are potentially vulnerable. (See I B Sample Content 1, 2, and 3)
    - b) Some children are more vulnerable than others. (See I C; II B)
3. The role of stress as the "triggering" mechanism
    - a) Stress may "trigger" action or inaction; i.e., abuse or neglect. (See II A and C)
    - b) Individuals differ in their ability to cope with stress. (See I C)
4. The role of the passive partner
    - a) Intervention by the partner may be possible. (See Unit II Case Histories.)
    - b) Absence of intervention by the partner will:
        - (1) Reenforce neglectful acts, or
        - (2) Reenforce abusive acts
5. The role of sibling on-looker(s)
    - a) Child maltreatment may be focussed upon one child at a time; i.e., only one child may be singled out. (See II C)
    - b) Child maltreatment may be used as a behavior pattern by the sibling. (See IV D.)
    - c) The sibling on-looker is also a vulnerable child.

Suggested Classroom Activities and Procedures for Performance Objectives 1 through 6

1. Review II. The Nature of Child Maltreatment.
2. Introduce Generalization III A and B and write on board for students.
3. Use a variety of techniques to clarify student understanding of the Definition of Terms (III.1a) 1 through 6 as appropriate.
4. Utilize the following to develop student understanding of the role of the potentially abusive or neglectful caretaker:

   Identity of the Caretaker, Transparency 6

   I B Sample Content 4

   Questions and Answers (I.4)

   Dysfunctions of Society, the Family, and the Individual (I.6)
5. Write III A Sample Content 1 on the board for students.
6. Utilize the following to develop student understanding of the role of the potentially vulnerable child:

   Typical Manifestations of Physical Abuse and Neglect (II.8) or Transparency 11a and b

   Typical Manifestations of Psychological Abuse and Neglect (II.9) or Transparency 12a and b

   I B Sample Content 1, 2, 3; I C; II B
7. Write III A Sample Content 2 on the board for students.
8. Discuss the negative aspects of stress in society, the family, and the individual.
9. Utilize the following to develop student understanding of the role of stress as the "triggering" mechanism:

   Unit II Generalizations A and C

   Unit I Generalization C
10. Have students read and discuss "How a Baby Learns to Love" (III.8) in relation to III A Sample Content 1 through 3 and Interpretations of

the Nurturing Experience (III.1b) Clarify student understanding of the term "nurturing." See Definition of Terms (III.1b)

11. Have students read and discuss "How To Conquer Stress" (III.10) and "Holiday Season Filled With Child Abuse" (III.13) in relation to III A Sample Content 1 through 3.
12. Refer students to Typical Manifestations of Psychological Abuse and Neglect (II.9) and discuss the possible role of the child as the stress factor.
13. Focus class attention on Generalization III B.
14. Write III B Sample Content 4 on board.
15. Utilize selected case histories from Unit II for class discussion of the role of the passive partner in relation to III B Sample Content 4.
16. Discuss the alternatives for the passive partner. (See VI A.)
17. Utilize the following to develop student understanding of the role of sibling on-looker(s):

    II C Sample Content 1 and 2

    IV D
18. Summarize utilizing Transparency 13 The Episode of Child Maltreatment and Transparency 10 Characteristics of Child Maltreatment
19. Conclude with assessment measures for Performance Objectives 1 through 6.

UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective

The student will be able to describe the components in an episode of child maltreatment.

Performance Objectives for Generalization C

7. IDENTIFY the potentially abusive or neglectful caretaker.
8. DESCRIBE the characteristics of the potentially abusive or neglectful caretaker.

Generalization C

THE POTENTIALLY ABUSIVE OR NEGLECTFUL CARETAKER IS REPRESENTATIVE OF A CROSS-SECTION OF ANY COMMUNITY IN TERMS OF RACE AND/OR SOCIAL OR ECONOMIC STATUS.

Sample Content

1. The Potentially Abusive or Neglectful Caretaker
    a) Frequently (90%)
        1) The emotionally immature
        2) The punitive and authoritarian
        3) The psychoneurotic

        - b) Less frequently (10%)
            - 1) The psychopathic
            - 2) The mentally impaired
    2. Characteristics of the Potentially Abusive or Neglectful Caretaker may be:
        - a) Abused or neglected in infancy or childhood
            - 1) Deprived of a nurturing experience in infancy or childhood
            - 2) Conditioned toward violence in human behavior
        - b) Isolated by choice or circumstance
        - c) Lacking self-esteem
        - d) Lacking understanding of the normal physical and psychological stages of child development
        - e) Unable to cope with stress

Suggested Classroom Activities and Procedures for Performance Objectives 7 and 8

1. Review the following:

    Appropriate definition of terms (III.1a)

    Identity of the caretaker (II.3)

    Role of the caretaker

2. Introduce Generalization III C and write on board for students.

3. Develop student understanding of III C through utilization of:
    - Review of Unit I B Sample Content 4
    - Questions and Answers About Child Maltreatment (I.4)
    - Dysfunctions of Society, the Family, and the Individual (I.6)
4. Show Transparency 14a
    - Emphasize "NOTE" on transparency and generality of terms.
    - Clarify student understanding of terms.
    - Emphasize the 90% in relation to III C.
5. Conduct class discussion of the 90% in relation to The Criteria for Emotional Maturity (III.4).
6. Conduct class discussion of the 90% in relation to Interpretations of the Nurturing Experience (III.1b).
7. Conduct class discussion of the 90% in relation to the role of stress as the "triggering" mechanism. See III A Sample Content 3.
8. Conduct class discussion of the 90% in relation to the child as the stress factor. See II.9.
9. Conduct class discussion of the 90% in relation to The Phenomenon of Child Maltreatment (I.6).
10. Repeat activities 5 through 9 using the 10%.
11. Write III C Sample Content 1 on board for students.
12. Show Transparency 14b.
    - Clarify student understanding of terms.
    - Emphasize "NOTE" on transparency.
    - Point out that the characteristics noted may be found also in the caretaker who is neither abusive nor neglectful.

13. Develop student understanding of the characteristics of the potentially abusive or neglectful caretaker as follows:

For Sample Content 2 a) see IV D and I C:

a) The caretaker deprived of a nurturing experience in infancy or childhood may experience difficulty in the adult nurturing role.

b) The caretaker conditioned in childhood toward violence in human behavior may adopt a behavior pattern of violence in later life. (See also the role of the sibling on-looker.)

For Sample Content 2 b) see II Case Histories and I C:

a) The caretaker may be isolated by choice; i.e., the social isolate.

b) The caretaker may be isolated by circumstances; e.g., absence of supportive person(s), friends, the extended family, pastor.

For Sample Content 2 c) see II Case Histories; I C; and the role of stress as the "triggering" mechanism.

a) Stress is ever present; i.e., a fact of life, both positive and negative.

b) Stress may trigger action or inaction; i.e., abuse or neglect.

c) Individuals differ in ability to cope with stress (II.4, 5, and 6).

d) The child as the stress factor (II.9)

For Sample Content 2 d) see I C and II C:

a) Lack of understanding as a dysfunction of society, the family, or the individual

b) Lack of understanding resulting from custom or oral tradition in child-rearing practices (I A)

For Sample Content 2 e) develop student understanding of:

a) Origins of self-esteem

b) Self-esteem in relation to ability to cope with stress

c) Self-esteem in relation to dysfunctions of society, the family, and the individual

14. Students may:

- Invite a resource speaker (child psychiatrist) to address aspects of Sample Content 2 e) in relation to the infant nurturing experience and/or the after effects of maltreatment in infancy or early childhood
- Carry out independent research on the development of self-esteem in the individual
- Read and discuss (or write a brief review) "Working with Abusive Parents -- A Social Worker's View/A Psychiatrist's View" (VI.11)
- Review and discuss VI C Sample Content 1 and 2
- Read and discuss "Child Care by Adolescent Parents" (III.11) in relation to characteristics of the potentially abusive or neglectful caretaker
- Research resources for the caretaker in Montgomery County
- Read and discuss "How A Baby Learns to Love" (III.8) and 'Battered' Babies, Birth Without Violence (III.9) in relation to a) Interpretations of the Nurturing Experience (III.1b) and b) the development of self-esteem

15. Conclude with assessment measures for Performance Objectives 7 and 8.

UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective

The student will be able to describe the components in an episode of child maltreatment.

Performance Objectives for Generalization D

9. IDENTIFY the potentially vulnerable child.
10. DESCRIBE characteristics of the potentially vulnerable child.
11. DESCRIBE the potentially vulnerable child from the viewpoint of the caretaker.

Generalization D

THE POTENTIALLY VULNERABLE CHILD MAY BE AN EXCEPTIONAL OR DEMANDING CHILD OR A NORMAL CHILD.

Sample Content

1. The potentially vulnerable child
    - a) The exceptional or demanding child
    - b) The normal child
2. Characteristics of the potentially vulnerable child
    - a) The exceptional or demanding child may be:
        - 1) Precocious or gifted
        - 2) Physically or mentally impaired
        - 3) Premature
        - 4) Emotionally disturbed
        - 5) Others

b) The normal child may be:

1) Stepchild
2) Foster child
3) Adopted child
4) Illegitimate
5) Undesired sex
6) Conceived prior to marriage
7) Sibling position (oldest; youngest, etc)
8) Unwanted pregnancy
9) One of twins or triplets
10) Others

3. Characteristics of the potentially vulnerable child from the viewpoint of the caretaker:

"too dumb"

"too smart"

"too slow"

"too burdensome"

"too independent"

"too dependent"

"too hard-to-comfort"

"needs too much comforting"

"poor eater"

"finicky"

"willful"

"stubborn"

"bad"

"spoiled"

"disobedient"

"whiney"

"fussy, irritable"

"smart aleck"

Suggested Classroom Activities and Procedures for Performance Objectives 9, 10, and 11

1. Review the role of the potentially vulnerable child:

    III A Sample Content 2

    I B Sample Content 1, 2, and 3

    I C

    II B

2. Introduce Generalization III D, and write on board for students.

3. Clarify student understanding of the terms.

4. Show Transparency 15a.

    Discuss selected case histories from Unit II in terms of the exceptional or demanding child.

    Discuss the exceptional or demanding child in relation to the Identity of the Caretaker (II.3)

    Discuss care of the exceptional or demanding child in relation to The Criteria of Emotional Maturity (III.4) and III.1b.

    Discuss the exceptional or demanding child in relation to the role of stress as the "triggering" mechanism.

    Discuss the exceptional or demanding child in relation to the role of the potentially vulnerable child as the stress factor.

    Emphasize NOTE on the transparency.

5. Write III D Sample Content 1 a) and b) on board for students.
6. Show Transparency 15b.

   Discuss selected case histories from Unit II in terms of the normal child.

   Discuss the normal child in relation to the Identity of the Caretaker (II.3)

   Discuss care of the normal child in relation to The Criteria of Emotional Maturity (III.4)

   Discuss care of the normal child in relation to the role of stress as the "triggering" mechanism (III A Sample Content 3).

   Discuss care of the normal child in relation to the role of the potentially vulnerable child as the stress factor.

   Emphasize NOTE on transparency.
7. Write III D Sample Content 2 on board for students.
8. Distribute copies of III D Sample Content 3 and have students try to identify whether an a) exceptional, b) demanding, or c) normal child is being described.
9. Discuss the exceptional, demanding, or normal child in relation to characteristics of the potentially abusive or neglectful caretaker.
10. Students may:
    - Invite a speaker to talk about resources for the maltreated child in Montgomery County

- Research resources for the maltreated child (See VI B Sample Content 1 and 2)
- Write a paper on dysfunctions in society, the family, or the individual in relation to the potentially vulnerable child
- Review and discuss Characteristics of Child Maltreatment Today (II.7)
- Review and discuss Typical Manifestations of Psychological Abuse and Neglect in the Child in relation to the exceptional or demanding child and the normal child (See II.9.)
- Roundtable discuss the potentially vulnerable child in relation to custom or oral tradition in child-rearing practices
- Invite a resource speaker (e.g., Child Development teacher) to discuss parenting skills for the normal child versus those for the exceptional or demanding child
- Research educational opportunities in Montgomery County for the development of parenting skills
- Invite a resource speaker (e.g., Special Education teacher) to discuss parenting skills for the exceptional child or demanding child versus those for the normal child.
- Invite a resource speaker (e.g., pediatrician, child psychiatrist) to discuss parenting skills for both the exceptional or demanding and the normal child.

11. Conclude with assessment measures for Performance Objectives 9, 10, and 11

UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective

The student will be able to describe the components in an episode of child maltreatment.

Performance Objectives for Generalization E

12. STATE the meaning of the term "stress."
13. LIST the characteristics of stress in relation to time (duration).
14. CLASSIFY the kinds of stress.
15. DESCRIBE the origins of stress.

Generalization E

STRESS, THE "TRIGGERING" MECHANISM, MAY ORIGINATE WITHIN SOCIETY, THE FAMILY, OR THE INDIVIDUAL.

Sample Content

1. Definitions of stress:
    a) Physical, mental, or emotional strain or tension within the individual
    b) Any condition or situation which produces strain or tension within the individual
2. Characterization of stress in relation to length of time (duration)
    a) Minutes, hours
    b) Days, months
    c) Years, indefinitely

3. Kinds of stress:
    a) An influence or influences
    b) An event or events
    c) A person or persons
4. Origins of stress:
    a) Within society (I C Sample Content 1)
    b) Within the family (I C Sample Content 2)
    c) Within the individual (I C Sample Content 3)

Suggested Classroom Activities and Procedures for Performance Objectives 12 through 15

1. Discuss briefly the positive and negative effects of stress, using general examples unrelated to maltreatment.
2. Review the role of stress as the "triggering" mechanism in the episode of child maltreatment. (III A Sample Content 3)

   Have students read and discuss III.10 and III.11.
3. Introduce Generalization III E, and write on board for students.
4. Clarify student understanding of the term stress, using III E Sample Content 1 a) and b).
5. Have students list examples of stress in relation to duration, using III E Sample Content 2 a) Minutes, hours; b) Days, months; c) Years, indefinitely.

   Write student examples on board according to the three categories above.

6. Emphasize the importance of an in-depth understanding of all aspects of stress, since stress is identified as one of the controlling factors in both child abuse and child neglect, physical as well as psychological or emotional.
7. Develop student understanding of the possible kinds of stress, using examples of III E Sample Content 3:a) An influence or influences; b) An event or events; c) A person or persons.
8. Have students use stress examples which they have listed according to duration (see #5 above) and regroup these examples into categories according to kinds of stress.
9. Refer students to III.3 and discuss examples of stress according to duration and kind in relation to the potentially abusive or neglectful caretaker.
10. Restate III E Sample Content 4, and refer students to Dysfunctions in Society, the Family, and the Individual (I.6) to develop student understanding of the origins of stress in relation to duration and kind.
11. Focus upon Dysfunctions of the Individual in relation to individual ability to cope with stress.
12. Utilize Transparency 16 a, b, and c and Transparency 17 a and b for students to relate examples shown to characteristics (duration), kind and origin of stress.
13. Use Transparency 17c and have students substitute examples of their own for those shown.
14. Show appropriate slides or film depicting child maltreatment.

15. Students may:

- Make a collage of stress examples according to duration, kind, or origin
- Discuss case histories from Unit II in relation to stress factors
- Make a chart similar to Transparency 17c, using many examples
- Invite a resource speaker (e.g., psychologist) to talk about the positive and negative aspects of stress upon the individual
- Invite a resource speaker (e.g., psychiatrist) to talk about individual coping mechanisms for stress
- Research offerings of the Montgomery County Mental Health Association for coping with stress
- Research possible areas of dysfunction in Montgomery County such as a) economic conditions; b) environmental conditions; c) social values; and d) institutions in relation to stress as the "triggering" mechanism
- List and discuss some of the controlling factors in individual ability to cope with stress
- Invite a member of the Montgomery County Child Protection Team to talk about stress in relation to the problem of child maltreatment in Montgomery County
- Roundtable discuss all aspects of stress as the triggering mechanism for abuse, physical and psychological; and neglect, physical and psychological.

16. Conclude with assessment measures for Performance Objectives 12 through 15.

EVALUATION

for

III. The Episode of Child Maltreatment

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1, 2, AND 3 -- UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective: The student will be able to describe the components in an episode of child maltreatment.

Generalization A, B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
1. LIST the components in an episode of child maltreatment.	Fill in blanks: The components in an episode of child maltreatment include ________, ________, ________, and often ________ and ________.	III Generalization A and B III.1a Transparency 13
2. EXPLAIN the role of the caretaker in an episode of child maltreatment.	Explain the role of the caretaker in two ways.	III A Sample Content 1 III.1a and 1b I B Sample Content 4 I.4 and I.6 Transparency 6 (10,13)
3. EXPLAIN the role of the child in an episode of child maltreatment.	Explain the role of the child in two ways.	III A Sample Content 2 III.1a and 1b I C I B Sample Content 1 - 3 II B II.8 and II.9 Transparency 11 a, b Transparency 12 a, b Transparency 10, 13

Key Word[1] (See Appendix A.)

LIST	- to make a series of words or statements
EXPLAIN	- to describe the relationship between things and/or [to] present the reasons for an occurrence or relationship.

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[1] Thomas Evaul. Behavioral Objectives, Their Rationale and Development (Merchantville, New Jersey: Curriculum and Evaluation Consultants), 1972.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 4, 5, AND 6 -- UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective: The student will be able to describe the components in an episode of child maltreatment.

Generalization A, B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
4. EXPLAIN the role of stress as the "triggering" mechanism in an episode of child maltreatment.	Explain the role of stress as the "triggering" mechanism in two ways.	III A Sample Content 3 III.1a and 1b III.10 III.11 I C II A II C II.9 Transparency 10 Transparency 13
5. EXPLAIN the role of the passive partner in an episode of child maltreatment.	Explain the role of the passive partner in: a) abusive acts b) neglectful acts	III B Sample Content 4 II[illegible].1a II Selected Case Histories VI A Transparency 10 Transparency 13
6. EXPLAIN the role of the sibling on-looker(s) in an episode of child maltreatment.	Explain the role of the sibling on-looker(s) in relation to: a) the characteristics of child maltreatment b) behavior patterns	III B Sample Content 5 II C Sample Content 1 & 2 IV D Transparency 10 Transparency 13

Key Word[2] (Appendix A.)

EXPLAIN - to describe the relationship between things and/or / to / present the reasons for an occurrence or relationship

---

[2] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 7 AND 8 -- UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective: The student will be able to describe the components in an episode of child maltreatment.

Generalization C Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
7. IDENTIFY the potentially abusive or neglectful caretaker.	a) Ninety percent of the potentially abusive or neglectful caretakers may be identified as: (1) (2) (3) a) Ten percent of the potentially abusive or neglectful caretakers may be identified as: (1) (2)	III C Sample Content 1 a) and b) III.1a III A Sample Content 1 I B Sample Content 4 I.4 I.6 II.3
8. DESCRIBE the characteristics of the potentially abusive or neglectful caretaker.	The potentially abusive or neglectful caretaker is characteristically described as: a) b) c) d) e)	III C Sample Content 2 III.1a and 1b III.4 III.8 III.9 III A Sample Content 3 I.6 I A I C II.4 II.5 II.9 II C II Case Histories IV D VI.11 Transparency 14 a, b

Key Word[3] (See Appendix A.)

IDENTIFY - to select from among several choices the item(s) that meet(s) certain criteria

DESCRIBE - to state a verbal picture or / to / list the characteristics of a person, place, thing, or event

---

[3] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 9, 10, AND 11 -- UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective: The student will be able to describe the components in an episode of child maltreatment.

Generalization D Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
9. IDENTIFY the potentially vulnerable child.	The potentially vulnerable child may be identified as: a) b) c)	III D Sample Content 1 III A Sample Content 2 III.1a III.5 I B Sample Content 1 - 3 I C II B II.3 Transparency 15 a
10. DESCRIBE characteristics of the potentially vulnerable child.	Give _____ examples of each of the above.	III D Sample Content 2 III.5 III A Sample Content 3 II Selected Case Histories II.3 Transparency 15 b
11. DESCRIBE the potentially vulnerable child from the viewpoint of the caretaker.	Give _____ examples of possible ways the caretaker may view the child.	III D Sample Content 3 II.7 VI B Sample Content 1 & 2

Key Word[4] (See Appendix A.)

IDENTIFY - to select from among several choices the item(s) that meet(s) certain criteria

DESCRIBE - to state a verbal picture or /_to_/ list the characteristics of a person, place, thing, or event

[4] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 12 THROUGH 15 --
UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective: The student will be able to describe the components in an episode of child maltreatment.

Generalization E Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 12. STATE the meaning of the term "stress."	Define the term stress.	The student will give correct information by utilizing the resources listed below: III E Sample Content 1 III A Sample Content 3 III.1a III.10 III.13
13. LIST the characteristics of stress in relation to time (duration).	TRUE/FALSE In an episode of child maltreatment, stress is usually only a few minutes in duration.	III E Sample Content 2 III A Sample Content 3 III.1a III.3 III.10 III.13 I.7 I.C II Slides or Film II Case Histories Transparency 16 a, b, c Transparency 17 a, b, c

Key Word[5] (See Appendix A.)

STATE - to make a declarative word phrase setting forth something
LIST - to make a series of words or statements

[5] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 12 THROUGH 15 -- UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective: The student will be able to describe the components in an episode of child maltreatment.

Generalization E Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 14. CLASSIFY the kinds of stress.	COMPLETION: In an episode of child maltreatment, the stress factor could be any one of the following kinds: a) b) c)	The student will give correct information by utilizing the resources listed below: III E Sample Content 3 III A Sample Content 3 III.1a III.3 III.10 III.13 I.7 I C II Slides or Film II Case Histories Transparency 16 a, b, c Transparency 17 a, b, c
15. DESCRIBE the origins of stress.	Give two examples of stress in relation to each of the following: a) Dysfunctions of society b) Dysfunctions of the family c) Dysfunctions of the individual	III E Sample Content 4 III.1a III.3 III.10 III.13 I.7 I C II Case Histories II Slides or Film Transparency 16 a, b, c Transparency 17 a, b, c

Key Word[6] (See Appendix A.)

CLASSIFY - to place into groups according to certain criteria

DESCRIBE - to state a verbal picture or / to /list the characteristics of a person, place, thing, or event

---

[6] Evaul.

CLASS RECORD FORM

S = SATISFACTORY

U = UNSATISFACTORY

UNIT III: THE EPISODE OF CHILD MALTREATMENT

CLASS ______________________________ PERIOD ______________

INSTRUCTIONAL OBJECTIVE: The student will be able to describe the components in an episode of child maltreatment.

	PERFORMANCE OBJECTIVE															AVERAGE %	
NAME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	S	U
AVERAGE % S																	
U																	

CLASS AVERAGE

GRADE KEY

S----SATISFACTORY for PERFORMANCE OBJECTIVES

U----UNSATISFACTORY for PERFORMANCE OBJECTIVES

60% SATISFACTORY = CREDIT for COURSE

STUDENT ____________________

FINAL GRADE

TOTAL % SATISFACTORY for COURSE ______

TOTAL % UNSATISFACTORY for COURSE______

INDIVIDUAL STUDENT RECORD

AVERAGE Instructional Objectives

	PERFORMANCE OBJECTIVES																				S	U
UNIT I Instructional Objective	1	2		3	4	5		6	7	8												
UNIT II Instructional Objective	1	2	3		4	5	6	7	8		9	10										
UNIT III Instructional Objective	1	2	3	4	5	6		7	8		9	10	11		12	13	14	15				
UNIT IV Instructional Objective	1	2	3		4	5	6	7	8		9	10	11	12	13		14	15	16	17		
UNIT V Instructional Objective One	1	2	3	4	5		6	7	8	9	10		11	12	13	14	15					
UNIT V Instructional Objective Two	1	2	3	4	5																	
UNIT VI Instructional Objective One	1	2	3	4																		
UNIT VI Instructional Objective Two	1	2																				

CLASSROOM INSTRUCTIONAL MATERIALS

for

III. The Episode of Child Maltreatment

SELECTED RESOURCES

1. Definition of Terms (III.1a)
2. Interpretations of the Nurturing Experience (III.1b)
3. The Components (III.2)
4. The Potentially Abusive or Neglectful Caretaker (III.3)
5. The Criteria of Emotional Maturity (III.4)
6. Characteristics of the Potentially Vulnerable Child (III.5)
7. Typical On-Going Stress Factors (III.6)
8. Typical Stress Factor Immediately Prior to Maltreatment (III.7)
9. "How A Baby Learns to Love" (III.8)
10. "'Battered' Babies, Birth Without Violence" (III.9)
11. "How To Conquer Stress" (III.10)
12. "Child Care by Adolescent Parents" (III.11)
13. "Mom and Dad" (III.12)
14. "Holiday season filled with child abuse" (III.13)
15. Classroom learning center for child maltreatment

AUDIOVISUAL MATERIALS

Overhead Transparencies

13. The Episode of Child Maltreatment, The Components
14. The Potentially Abusive or Neglectful Caretaker (a and b)
15. Characteristics of the Potentially Vulnerable Child (a and b)
16. Typical On-Going Stress Factors (a, b, c)
17. Typical Stress Factors Immediately Prior to Maltreatment (a and b)

17c World of Abnormal Rearing

Films

Birth Without Violence A film depicting the birth delivery techniques of Dr. Frederick Leboyer, who has himself delivered more than 10,000 babies. Though considered radical by some, his supremely simple technique seemingly eases the birth trauma and helps the new human being to start life without pain, confusion and fear. Recommended for classroom use, where available.

Second Chance. The treatment of maternal deprivation syndrome is described in this film. A deprived 22-month-old child is seen through the period of hospitalization at the Chicago Children's Memorial Hospital. The profound effects of the lack of emotional care, the child's defensive reactions to maltreatment, and her improvement after therapy are illustrated and explored.

Children's Memorial Hospital 1974, color 12 min. Available through MCPS Film Library

THE EPISODE OF CHILD MALTREATMENT

*DEFINITION OF TERMS (III.1a)

1. Potential	adj.	- 1: existing in possibility: capable of development into actuality
2. Vulnerable	adj.	- 1: capable of being physically wounded 2: open to attack or damage
3. Stress	n.	- 1: constraining force or influence: as c: a physical, chemical, or emotional factor that causes bodily or mental tension d: a state resulting from stress
4. Positive	adj.	- 6a: marked by or indicating acceptance, approval, or affirmation b: affirming the present of that sought or suspected to be present
5. Negative	adj.	- 1a: marked by denial, prohibition, or refusal 2b: marked by features (as hostility or withdrawal) opposing constructive treatment or development
6. Passive	adj.	- 3a: receiving or enduring without resistance: SUBMISSIVE
7. Punitive	adj.	- 1: inflicting, involving, or aiming at punishment
8. Authoritarian	adj.	- 1: relating to or favoring blind submission to authority
9. Psychopathic personality	n.	- 1: an emotionally and behaviorally disordered state characterized by clear perception of reality except for the individual's social and moral obligations and often by the pursuit of immediate personal gratification in criminal acts, drug addiction, or sexual perversion
10. Psychoneurosis (Psychoneurotic) adj.	n.	- 1: a neurosis based on emotional conflict in which an impulse that has been blocked seeks expression in a disguised response or symptom
11. Nurturance	n.	- affectionate care and attention
Nurture	n.	- 1: TRAINING, UPBRINGING 3: the sum of the influence modifying the expression of the genetic potentialities of an organism. (See Interpretations of the Nurturing Experience (III.1b).

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* *Webster's New Collegiate Dictionary*, 1974.

INTERPRETATIONS OF THE NURTURING EXPERIENCE (III.1b)

".....the process in which an adult takes care of an infant; that is, a theoretically mature capable, self-sufficient person caring for a helpless, needy, dependent, immature individual...Mothering consists of feeding, holding, clothing, and cleaning the infant...along with the more subtle ingredients of tenderness, of awareness and consideration of the needs and desires of the infant and of appropriate emotional interaction with it."

".....the deep, sensitive, intuitive awareness of and response to the infant's condition and needs, as well as consideration of the infant's capacity to perform according to his age."

From "A Psychiatric Study of Parents Who Abuse Infants and Small Children" by Brandt F. Steele and Carl B. Pollock in The Battered Child, edited by Ray E. Helfer and C. Henry Kempe. Chicago: The University of Chicago Press (1974).

".....intimacy, empathy, trust and 'mothering', used in the generic sense of mother-father parenting. Intimacy as the positive outgrowth of a willingness to risk a sharing of onesself with another is seen as an expression of a bond of affection and closeness between 'parent and child'--Intimacy is the emotional touching that leads to affectional fulfillment in an interpersonal relationship. It is the foundation stone to family harmony."

From "Parent Surrogate Roles: A Dynamic Concept in Understanding and Treating Abusive Parents" by Morris J. Paulson and Anne Chaleff in Journal of Clinical Child Psychology, Vol. II (3) Fall 1973.

(Transparency 13)

THE EPISODE OF CHILD MALTREATMENT

THE COMPONENTS (III.2)

1. The Potentially Abusive or Neglectful Caretaker
2. The Potentially Vulnerable Child
3. Stress, the "triggering" mechanism
4. The Passive Partner
5. The Sibling On-looker(s)

(Transparency 14)

THE EPISODE OF CHILD MALTREATMENT

*THE POTENTIALLY ABUSIVE OR NEGLECTFUL CARETAKER (III.3)

THE POTENTIALLY ABUSIVE OR NEGLECTFUL CARETAKER IS REPRESENTATIVE OF A CROSS-SECTION OF ANY COMMUNITY IN TERMS OF RACE AND/OR SOCIAL OR ECONOMIC STATUS.

1. The Potentially Abusive or Neglectful Caretaker
    a) Frequently (90%)
        1) The emotionally immature
        2) The punitive and authoritarian
        3) The psychoneurotic
    b) Less frequently (10%)
        1) The psychopathic
        2) The mentally impaired
2. Characteristics of the Potentially Abusive or Neglectful Caretaker may be
    a) Abused or neglected in infancy or childhood
        1) Deprived of a nurturing experience in infancy or childhood
        2) Conditioned toward violence in human behavior
    b) Isolated by choice or circumstance
    c) Lacking understanding of the normal physical and psychological stages of child development
    d) Lacking in self-esteem
    e) Unable to cope with stress

*NOTE: There is continuing research in terms of prevention to determine the characteristics of the potentially abusive or neglectful caretaker.

THE EPISODE OF CHILD MALTREATMENT

THE CRITERIA OF EMOTIONAL MATURITY (III.4)

HAVING the ability to deal constructively with reality

HAVING the capacity to adapt to change

HAVING a relative freedom from symptoms that are produced by tensions and anxieties

HAVING the capacity to find more satisfaction in giving than receiving

HAVING the capacity to relate to other people in a consistent manner with mutual satisfaction and helpfulness

HAVING the capacity to sublimate, to direct one's instinctive hostile energy into creative and constructive outlets

HAVING the capacity to love

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(Transparency 15 a and b)

THE EPISODE OF CHILD MALTREATMENT

*CHARACTERISTICS OF THE POTENTIALLY VULNERABLE CHILD (III.5)

THE POTENTIALLY VULNERABLE CHILD MAY BE AN EXCEPTIONAL OR DEMANDING CHILD OR A NORMAL CHILD. All children may be vulnerable. Some children may be more vulnerable than others.

1. The exceptional or demanding child may be:
    - a) Precocious or gifted
    - b) Physically or mentally impaired
    - c) Premature
    - d) Emotionally disturbed
    - e) Others

2. The normal child may be:
    - a) Stepchild
    - b) Foster child
    - c) Adopted child
    - d) Illegitimate
    - e) Undesired sex
    - f) Conceived prior to marriage
    - g) Sibling position (oldest, youngest)
    - h) Unwanted pregnancy
    - i) One of multiple birth
    - j) Age
    - k) Others

*NOTE: There is continuing research in terms of prevention to determine the characteristics of the potentially vulnerable child.

(Transparency 16 a, b and c)

THE EPISODE OF CHILD MALTREATMENT

*TYPICAL ON-GOING STRESS FACTORS (III.6)

Insufficient income

Heavy financial debt

Misuse of adequate income

Unemployment

Poor work stability

Physical illness or injury

Alcohol addiction

Other drug addiction

Mental retardation

Currently receiving treatments at mental health facility

Marital

Religious differences

Work related

New baby in the home

Pregnancy

Heavy and continuous child care responsibility

Absence of essential family member

Physical abuse of spouse

Police/court record (excluding traffic)

Newcomer to household

Recent relocation

History of abuse as a child

Repetition of family style

Normal method of discipline

Other

None apparent

*National Standard Form--0023
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The American Humane Association, Denver, Colorado
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(Transparency 17 a and b)

THE EPISODE OF CHILD MALTREATMENT

*TYPICAL STRESS FACTORS IMMEDIATELY PRIOR TO MALTREATMENT (III.7)

Family breakup

Job related difficulties

Health problems

Argument

Physical fight

Under the influence of alcohol

Other drugs

Child's incessant crying

Child's disobedience/loss of control during discipline

Child's hostility or provocation

Child's resistance to perpetrator's sexual advances

Other immediate stress

None apparent

*National Standard Form--0023
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HOW A BABY LEARNS TO LOVE

by Selma Fraiberg

The author of *The Magic Years* describes a mysterious current that flows from baby to mother and back to baby again, creating the bond of love that proves to be the basis of life itself

During the past two decades a number of child-development specialists have started a new trend in the scientific study of babies. They began to sneak off one by one from their consulting rooms and their laboratories and camped out in homes where new babies had just arrived. I was one of them. We took along pencils and paper, cameras and tape recorders, and said to baffled mothers, "Don't mind us. Just do everything you ordinarily do in the course of the day. We want the baby to teach *us* a few things."

The mothers quite frankly thought we had lost our minds. But if the doctors wanted to learn how to diaper an infant or how to get a spoonful of mashed peas into a baby with a mind of his own, the mothers felt, Well, just go ahead. Actually there were no benefits to the parents; but sometimes if a mother needed an hour of emergency baby sitting, it was a comfort to know that a Harvard professor was available who could entertain the baby with the Audubon bird whistle he kept in his kit.

Among the many things we scientists wanted to learn in this camp-out was one very elusive question: How does the baby learn to love? Since no infant has ever been known to say to his mother, "I love you," the scientific work had to attack the problem by inference. What are the *signs* of love and attachment during the first eighteen months of life?

Over a period of years many of the scientists found agreement about certain signs. If we follow the growth of the infant's human attachments from the first day of his life to the end of his first year, we find that he responds to his mother and his father in ways that show increasing preference. And finally we see that he values his parents above all other persons in his small world. And because the mother is the primary figure during the *first* year of life, the selective responses to the mother became a social guide for all the scientists engaged in this work.

What are the signs?

During the first six months the baby has the rudiments of a love language: *(Continued on page 104)*

Mrs. Selma Fraiberg, professor of child psychoanalysis, University of Michigan Medical School, and director of the Child Development Project, University of Michigan Medical Center, has taken part in numerous investigations dealing with the absence or rupture of human ties in infancy. Her perceptive and entertaining book "The Magic Years" tells how a child views his world.

there is the language of the smile, the language of vocal sound-making, the language of the embrace. It's the essential vocabulary of love before we can yet speak of love. (In 33 years, when the baby is grown and "falls in love" for the first time, he will woo his partner through the language of the smile, through the utterance of endearments and the joy of the embrace.)

How does the smile become part of the vocabulary of love? The smile is innate, the universal greeting sign of our species. Already in the early weeks of life it appears in deep sleep; then gradually it is elicited more and more frequently by external stimuli. At three months of age the one stimulus that will automatically produce a smile is the human face. At this age *any* human face will elicit a smile, which seems a poor reward for maternal devotion, but between three months and six months the smile becomes a smile of preference—for the mother.

The baby smiles more frequently for his mother than for others and his smiles for her are bigger and more joyful. During the same period he "talks" more, jabbers more fluently, with his mother than with a stranger. And if he is frightened or has taken a bad bump, he cannot be comforted by "just anyone" any longer; he seeks the comfort of his mother's arms. His mother's arms and her lap, the closeness of her body, have a magical quality in soothing him and creating the feeling that all is well.

At this stage, then, the baby has discriminated his mother from others, shows preference for her and associates her with the satisfaction of his hunger and body needs. But, we ask ourselves doubtfully, is this "love"? Not yet, perhaps. But these are signs of selection, of intimate exchange and partnership, that will lead him to love.

Between six and 12 months something new begins to emerge. The baby now begins to show us another way in which he places special value upon his mother. While he has always been sociable and smiled for the uncle who wiggled his ears or for the lady in the red dress, he now begins to become downright unsociable. In place of a smile they may get a look of cold scrutiny, or a frown, or—regrettably—a howl of indignation.

The infant's parents are quick to offer apologies. "I don't know what's got into him! He used to be so friendly." What's-got-into-him is something the baby specialists call *stranger reaction*, perfectly normal behavior between six and 15 months. It means, very simply, that his mother for the time being is the center of his world and the "stranger" is somehow an intruder, someone who unsettles the intimacy and safety of the private world. Typically, after the baby produces a negative reaction to the stranger his eyes will begin to search the room for his mother, and when he finds her face he bestows a big smile upon her and then may make overtures to be picked up.

Odd as it may sound, this behavior toward strangers is one of the signs of the baby's increasing affection for his mother. All love, even in later life, begins with a feeling of exclusiveness. "You are the one who matters—only you." It's the magic circle of love that in infancy includes the father and a few other choice people but not yet the stranger. In a few months, by the way, the baby will receive strangers quite hospitably again, but that's because he is secure enough to feel that the magic circle is no longer threatened by outsiders.

At around the same time, about eight months of age, the baby shows his growing love for his mother in still another way. He complains when he is separated from her. He may not object if she leaves him to go to the kitchen, but his face is very likely now to pucker up when he sees her in her hat and coat. And his baby sitters may report that he complains loudly for a time after she leaves.

"Do you think he's spoiled?" some mothers and fathers will ask. But he's not spoiled. At this time his mother is still the most important person in his world. And he behaves the way all of us behave when a loved person is absent for a while: "I can't bear to be without you. I am lost. . . . I am not myself when you're gone. . . . You are my world, and without you the world is empty."

If all this seems too extravagant to put into the minds of babies, we need only watch an infant of this age whose mother has been called away on an emergency for several days or a baby who has been isolated from his mother in a hospital. The face of grief is no different at eight months from that at 30 years of age. Loss of appetite, sleeplessness, refusal of comfort from someone else—for both ages the symptoms are the same.

From this short sketch we can see that by the end of the first year the baby has gone through a sequence of phases in his human attachments—from simple recognition of the mother to recognition of her as a special person to the discovery that she is the source of joy, the satisfier of body hungers, the comforter, the protector, the indispensable person of his world. In short, he has learned to love.

This is what we learned from scientific camping out in the homes of babies.

Another group of scientists chose to study babies who had been reared from birth in institutions as well as babies reared in their own families. And they emerged with a different story.

In the institutions—even the best ones—no baby has a mother or a mother substitute. There may be 12 to 30 babies in a ward with two to four nurses or aides for each of three shifts. No one person, no matter how much she loves babies, can serve as mother substitute under these circumstances. The infant is fed, bathed and changed by a rotating staff. In many institutions it saves staff time to feed the baby by means of a propped-up bottle. A good part of his time is spent in a crib during the first year of life.

At three months of age, when our home-grown babies smiled in response to the human face, the babies in institutions smiled too. The smiles were not as frequent, some of the scientists noted, but they were there. The babbling sounds that babies make at three months were made by the institutional babies also—but their vocalizations were less frequent than those of family-reared babies and seemed to have a more limited range of sounds.

Then between three months and 12 months of age something that should happen to the smile and something that should happen to vocalizations did not appear in the institutional babies. At a time when the home-reared baby showed preference with huge smiles for mother and father, the institutional baby smiled indifferently at everyone he saw. And around six to 12 months, the time when the family baby reserved his smile for the members of the magic circle and showed negative reactions toward strangers, the institutional baby behaved no differently toward the daily nurses and attendants and casual visitors to the nursery whom he had never seen before.

Everyone had equal value in his eyes because no one had special value. Anyone who created a diversion in the monotony of the nursery day could get a smile.

During a period when the family-reared infant began to carry on "conversations" in gibberish with his mother and father and when he began to imitate sounds (around eight months of age), the institutional baby had a restricted range of sounds. He was not imitating sounds; and the melodies of speech, which emerge at this time like an absurd parody of English, were not present at all.

How odd! we think. These institutional babies were exposed to all the ordinary conversational exchanges of nurses and aides; they were not being reared in isolation. But findings such as these are very common among institutional babies. From this we learn that while the brain is "programed" so that a full range of articulations are available to every normal infant, the organization of these sounds into patterns and the use of these sounds for communication is entirely dependent upon the existence of human partners.

We can confirm this very simply as adults. It is possible to live in a foreign country for months, exposed to the native language day after day, and not acquire even the rudiments of discourse in that language if there is no relationship with a native who speaks the language, someone who provides the conditions for dialogue.

The institutional babies had heard the sounds of English all around them, but because there were no partners to provide the intimate exchange that is vital to the acquisition of language, they were slow to acquire the sounds and the cadences of that language. And if they remained in the institution for the early years of life, speech became one of the areas of severe retardation in their development.

How did the institutional infants react to separation from the nurses and aides who were the only representatives of a human world? We know that babies reared in their own homes show distress at a mother's absence, and if absence is prolonged, there is terrible grief. We understand that pain at separation is another measure of the child's love for his mother. But the institutional baby showed no signs that the absence of one or another of the people who cared for him had any meaning to him. If the red-haired nurse took a two-week vacation, there were five other nurses who performed identical duties and were interchangeable parts in the human machine that fed, bathed and changed him.

In many of the institutions, babies were placed in foster homes in the second and third years, and the possibilities of human bonds were opened up to them. But some of the babies spent their early years in the institution without human partners, without intimacy. And these children offered science the most chilling testimony for the power of love.

At the age of three and four they were already different from other children. They continued to show by their behavior that one adult was interchangeable with any other adult, and they were measurably retarded in speech and abstract thinking.

In follow-up studies in later childhood and in adult life the scientists found many of them in social agencies, in clinics and in courts. Their life problems were in all cases different, of course, but they all suffered from the most extreme effects of a love-starved infancy. They had one thing in common—they were unable to form stable human bonds, unable to love. They were rootless and unbound, without partners—or, often, with casual and shifting partners, since no one partner was valued.

Of the children who had spent their early years in institutions, some managed to become relatively well adjusted adults, able to make meaningful, if limited, human associations. But many of the children who had never known physical closeness or the certainty of satisfaction of body hungers became men and women who seemed to have no pleasure in body intimacy and whose sexual appetites were impoverished or bizarre. Aggression, which is normally modified in the early years through the agency of love, appeared in these loveless men and women in erratic forms, sometimes fused with eccentric sexual practices. The human capacity for empathy, for feeling oneself into another personality, was simply absent. And because there can be no conscience without the capacity to feel for another, there was a vacant space in personality where conscience should have been.

Once again the scientific question led back to the first years of life. What was it, we asked ourselves, that transpired between an ordinary baby and his parents that usually guaranteed the capacity for love in later life? Surely since the dawn of mankind and in every society the human family has produced and nurtured babies who grew into men and women capable of experiencing enduring love and physical joy. In contemporary "primitive" societies, simple and illiterate parents achieve this miracle by simply doing what their ancestors have been doing for thousands of years.

It appears that the "program" for infant-mother attachment was laid down in our biological ancestry. It has much in common with the infant-rearing practices of all mammals and has close resemblance to infant rearing among the higher primates.

In the biological program we inherit, an infant leaves intrauterine life and comes into a radically changed environment. He is cushioned against the shock of the journey—from the water world to the land world, from enclosed space to unclosed space—but he brings little instinctive baggage into the world to ensure his adaptation or his survival. As a specimen of our genus, he is unfinished by comparison with the newborn of other species.

At the end of his journey there are provisions in the program that the woman who sheltered and nourished him in intrauterine life should be the woman to shelter and nourish him outside the womb. Body intimacy, the shelter of enclosing arms and nourishment are all marvelously contrived in the program to center around the mother's breast.

In breast feeding, the infant is cradled in the mother's arms. Pleasure in sucking, the satisfaction of hunger, intimacy with the mother's body, are united with his recognition of her face. The baby learns to associate *this* face, his mother's face, with an enjoyable and comforting experience. As we watch this intimacy give the baby the body closeness and sensual pleasure that are the first requirements of love. Many mothers who feed by means of the bottle choose to take over all or most of the feedings themselves. There is probably no reason why Father or Grandma cannot take over an occasional feeding. But when Mother is the main person who feeds him, the baby will *recognize* her earlier and begin to respond to her as a very special person, another requirement of love.

Thus most mothers have maintained the traditions while substituting the bottle for the breast. But today in many thousands of families, as well as in institutions for the care of infants, the old traditions have been lost. In many busy households or nurseries the baby is fed by means of a propped-up bottle and is deprived of one of the vital nutriments for love. Alone with his bottle in his crib, he will not learn to associate feeding with body intimacy and the face of his mother. And in cases when a baby is fed during his bottle feeding by someone other than his mother he may not associate feeding with pleasure and intimacy in relation to a central person—which disturbs the conditions for the love bonds.

The bottle gives a mother far more mobility than the breast, which is one of the reasons for its growing popularity during the past two decades. And a baby today experiences many more separations from his mother than the baby in the traditional breast-feeding societies. How does this affect the stability of the bonds to his mother?

At this point none of us can know for certain how changes in baby rearing have affected the development of children in our society during the past 20 years. I have cited the evidence from extreme cases, the babies in institutions who received no mothering. What we have learned from these tragic life stories is sobering, but the lesson also should be read as a testimony for love. It means that something goes on between an ordinary baby and ordinary mothers and fathers that creates and ensures the capacity for love in infancy and in later life. It tells us that love and pleasure in the body begin in infancy and progress through childhood and adolescence to a culminating experience, "falling in love," the finding of the permanent partner, the achievement of sexual fulfillment.

In every act of love in mature life there is a prologue that originated in the first year of life. There are two people who arouse in each other sensual joy, feelings of longing and the conviction that they are absolutely indispensable to each other—that life without the other is meaningless. Separation from each other is intolerable. In the wooing phase and in the prelude to the act of love the mouth is rediscovered as an organ of pleasure and the entire skin surface is suffused with sensual joy. Longing seeks its oldest posture, the embrace.

In the first falling in love, every pair of lovers has the conviction that "nothing like this has ever happened to me before. I never knew what love could be." And this is true, but only in a certain sense. The discovery of the partner, the one person in the world who is the source of joy and bliss, has its origin in the discovery of the first human partner in infancy. What is new is the *new* partner and the experience of genital arousal with longing for sexual union. Yet the pathway to full arousal in mature life was laid down in infancy, long before the genitals could play a dominant role in experience. It was the infant's joy in his own body, the fullness of infant sensuality, that opened the pathways to fulfillment in maturity.

Freud said all this 65 years ago and there were few who believed him. THE END

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B 6 Thursday, May 8, 1975 —LEISURE—

Book World

'Battered' Babies

BIRTH WITHOUT VIOLENCE. By Frederick Leboyer.
(Knopf, 142 pp. $7.95)

Reviewed by
Marourneen McCarthy

The reviewer is a registered nurse with experience in obstetrics.

Thanks to such sources as newspapers, magazines and congressional committee reports, the public has been learning the details about child abuse. Battered children can be victimized in the homes of the wealthy as well as the poor. Parents who brutalize their young were often physically abused in their own childhood. In general, what we have been learning is that child abuse is more widespread than we had thought, if we thought about it at all. In "Birth Without Violence," Frederick Leboyer, a French obstetrician, takes us even further, raising a number of unsettling questions about the pain that parents, doctors, nurses and the medical community unthinkingly inflict on babies at birth.

The world *unthinkingly* is important. Doubtless all those involved in the birth process see themselves as being careful or tender, the infant's fragility being obvious to everyone. Leboyer, who has assisted at 10,000 births, makes a forceful case for the need to understand why infants suffer so much at birth. "What makes being born so frightful is the intensity," he writes, "the boundless scope and variety of the experience, its suffocating richness.

"People say—and believe—that a newborn baby feels nothing. He feels everything.

"Everything — utterly, without choice or filter or discrimination.

"Birth is a tidal wave of sensation, surpassing anything we can imagine. A sensory experience so vast we can barely conceive of it."

Leboyer's purpose is one of advocacy on behalf of the newborn. He suggests, for example, that lights be dimmed in the delivery room at the time of birth. With lamps and floodlights aimed at the new arrival, "the infant howls aloud. And why should this surprise us? Its eyes have just been burned.

"They say a newborn child is blind? No, it is *blinded*."

It is much the same for the other delicate sense, hearing: "Who bothers to lower his voice in the delivery room?" Leboyer asks. "There is more shouting than speaking:

"'Come on! Push, push! Again, again!'"

As for the method of catching the baby, when the physician seizes him and handholds him upside down, Leboyer says that such a grip is "convenient. Convenient for us.

"And for the infant?

"What does it feel, finding itself suddenly upside down?

"Indescribable vertigo."

Much of Leboyer's thinking is surely new to those working in the nation's delivery rooms. His sensitive portrayal of the beginnings of life, and our contributions of pain to those beginnings, reveal an original mind pondering the oldest of subjects.

After saying that, though, there is an incompleteness to his thoughts. He gives us new knowledge but fails to suggest how to use it. Does he think for a minute that those who run hospital delivery rooms are going to put the lights low or that doctors at 3 a.m. are going to heed his advice: "to protect newborn children from fear, we must unveil the world to them infinitely slowly, in an endless sequence of severely limited revelation"? Hardly. For whatever reasons—routine, efficiency, financial costs—hospitals treat a delivery as a medical procedure, not an emotional event.

Leboyer had an ideal opportunity to take the discussion further along so that we could learn from him how some changes might be made. They assuredly won't be made, say, when a woman is wheeled into the delivery room and requests that the lights be dimmed and everyone talk in whispers. Leboyer neglected also to suggest that medical schools begin teaching future obstetricians about the tumult of birth, so that at least there is a chance for enlightenment among the younger doctors not yet set in their medical ways. Instead of discussing how hospitals have put technology between mother and child, and suggesting that women begin thinking about the logical alternative of home birth—where the mother can indeed ask that the lights be dimmed, talk be restrained and other kindnesses be shown the infant—Leboyer concludes by issuing a call that makes him sound like the Rod McKuen of the delivery room: "At the end of our tale, I can say only one thing: 'Try.'

"Everything that has been said here is simple. So simple that one feels ashamed to be so insistent about it.

"Perhaps we have lost our taste for the simple."

Or maybe we have lost our taste for taking on the complex—the habits of doctors, the convenience of nurses, the customs of hospitals—which is what Leboyer appears to have done.

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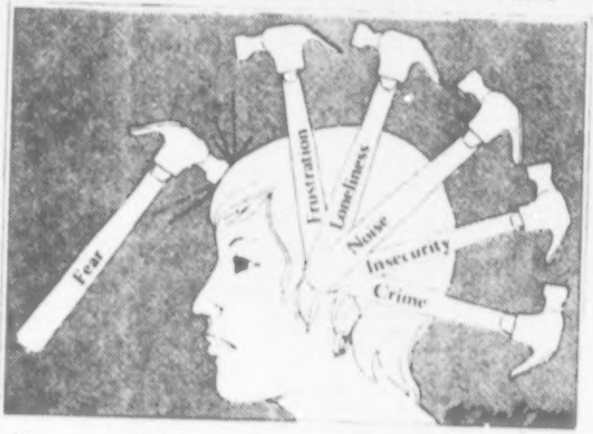
HOW TO CONQUER STRESS

By JOHN PRUTTING, M.D., with PATRICIA CURTIS

Must we pay with our health for the tensions of our modern world? Not if we learn what causes emotional wear and tear and how to minimize it in our daily lives



"THAT REALLY makes my blood boil!" said a man in my office recently, referring to something that angered him. Another patient used a familiar expression when she described a relative who lived with her as "a pain in the neck." These are not merely picturesque sayings—they are recognitions of the cause-and-effect connections between emotions and physical reactions. Our language is full of such idioms. Suppose you were faced with a tense situation. "My stomach is tied up in knots," you might say—and you would not be far from wrong. The accelerated heartbeat and rise in blood pressure (which prompts an expression like "blood boiling"), the neck pain, the stomach spasm are all symptoms of the same thing—stress.

People tend to think of stress as synonymous with nervous tension or pressure or emotional upset. These are not themselves stress, but if prolonged or severe, they can produce stress. Medically and biologically, stress is a state in which a chain of glandular and hormonal reactions takes place to help the body adapt to its physical and emotional environment. Not all of these reactions are necessarily destructive. They make it possible for you to accomplish difficult tasks, withstand physical and emotional shock, cope with trying situations, combat disease, heal damaged body tissue; they enable you to perform a superhuman feat in a crisis, or to do something as simple as adjust to extreme changes in weather. But when these adjustment demands on the body are extreme, or continual, the body's adaptive mechanisms may break down, and you can become ill—even die.

While the world has known for centuries that emotions can cause physical symptoms, it is only comparatively recently that doctors and medical researchers investigating hormones and body chemistry have begun to understand how destructive stress can be. Colitis, asthma, heart diseases, ulcers, gout, high blood pressure, headaches, rashes, constipation, infections—an alarming list of illnesses can be directly or indirectly traced to stress. Muscle spasms are typical indications of stress—they show up as stomach cramps, pains at the back of the neck, a feeling of fullness in the throat due to spasm of the throat muscle (*globus hystericus*). Severe premenstrual tension and menopausal symptoms can be due to stress. Sex drive and ability to perform are destroyed by stress.

Let's look at some hypothetical case histories of people who could be any of us.

- Mary C., a legal secretary and young newlywed, moved with her husband to a city 1,000 miles from the small town where she had lived all her life. She settled into her tiny apartment and went about finding a job. The lawyer who hired her was pleasant and considerate, but she soon discovered that his senior partner was a driving, disagreeable tyrant who continually interfered with everyone and everything in the office. One day he wrongfully accused Mary of making a mistake and told her boss that if it happened again, her boss would have to fire her.

Mary's husband was sympathetic enough, but she missed her family, especially her sisters, with whom she had always been able to share her troubles. Because she was naturally shy, she had not yet made any close friends in the city.

Meanwhile, she began to notice that her husband had started to drink excessively. He explained that his job as a salesman involved a great deal of socializing at lunch and after work, but Mary privately worried because he often kept right on drinking when he came home in the evening.

Mary became more and more frustrated and unhappy, both at work and at home. She began to suffer from headaches, a feeling of pressure in the back of her head. She had frequent abdominal cramps and diarrhea. Shortly after a letter from home told her that

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Reprinted from January 1972 issue of Family Circle Magazine.

her mother was ill, Mary broke out in a severe rash, especially prominent on her legs and ankles. She consulted a doctor.

On examining Mary, the doctor found she had an elevated blood pressure and extreme neck muscle spasm, and tests he ordered showed a spastic colon and changes in her body chemistry. The rash turned out to be caused by a deficiency of Vitamin C—even though Mary drank orange juice and took vitamin pills every day. Mary's symptoms were due to that great destroyer of health, stress. The adaptive mechanisms of her body had broken down under prolonged frustration, loneliness and worry and were causing the potentially dangerous physical reactions.

- Joe M., an engineer, had always been a self confident man bursting with good health and blessed with a calm disposition. He was content in his work, liked and trusted by the people in his department. At home, he was a steady, loving husband and father.

About a year ago it became apparent that the increasing air traffic at the huge airport near Joe's home was making life unbearable. The noise overhead bombarded the neighborhood day and night. Joe and his wife wanted to buy a new home elsewhere, but the engineering firm Joe worked for was suffering a recession. Many of Joe's associates had lost their jobs; he never knew when he might be next.

Gradually this robust man began to lose weight and tire easily. He was often unable to fall asleep, or was awakened by nightmares. His formerly happy sex life was affected. His wife was considerate and uncomplaining for, although she didn't realize how precarious Joe's job actually was she suspected he was worried. But Joe in turn worried further about her disappointment in him.

Then one Saturday Joe was working with a flammable fluid in his garage. Probably because he was overtired, he failed to observe the normal safety measures, and some of the fluid exploded. Joe suffered some painful burns.

Joe's doctor, in treating the burns, found that they healed very slowly, became infected easily, and that Joe's general body resistance was extremely low. While he was still being treated for the burns, Joe developed an ulcer and cardiac irregularities. Tests showed Joe's glandular reactions were abnormal and his cholesterol was high. The glands that produce tissue-healing hormones were not functioning as they should to mend his burns. Like Mary, Joe was in a state of stress, brought on by a breakdown of his body's ability to defend itself and adjust to such destructive forces as noise, anxiety, trauma and pain.

→ page 100

- Sarah D., a 46-year-old nursing supervisor, had been distressed for over a year about her only son, who had dropped out of college and moved to California. She had only a vague idea of where and how he was living, for he rarely communicated with her. Her best friend became ill with what Sarah learned was cancer. Sarah had just been hit with a staggering rent increase. Muggings and robberies in her part of town were increasing, too.

One day Sarah noticed she had developed periorbital edema (swelling around her eyes) and painful swelling of her breasts. When she consulted her doctor, he noted that her ankles were somewhat swollen also, and that she had gained weight.

Water retention is a symptom of stress that could have its roots deep in our primitive origins. When early man felt fear or anxiety, he was usually threatened with some kind of encounter in which he would have to run or fight for his life. His body would perspire (perspiring is the body's cooling mechanism, needed during heavy activity), drawing from its reservoir of fluids. But in the case of human beings today, anxiety is rarely resolved in flight or battle, so there is no excessive perspiration to use up the stored water. The usual result is water retention, such as Sarah's.

SOMETIMES STRESS can affect a whole population. A dramatic illustration of this was the phenomenally high rate of hyperthyroidism, a disease of the thyroid gland, in Denmark during the German occupation. Hyperthyroidism, in fact, reached epidemic proportions. It could not be traced to any cause other than the occupation; the rate went down when the Germans left.

Much of our understanding of stress comes from the work of Dr. Hans Selye, Professor and Director of the Institute of Experimental Medicine and Surgery at the University of Montreal. Dr. Selye's experiments revealed some crucial facts about the hormonal and glandular changes that take place in living beings when they are in stressful situations. In one series of experiments, he subjected large numbers of laboratory animals to such conditions as fear, frustration, noise, hunger, cold, overcrowding—and discovered that whatever the type of stress factor, after a sufficient length of time, the animals all showed approximately the same internal damage: Abnormal changes of the adrenal cortex and of the thymicolymphatic system, and gastrointestinal disorders. Dr. Selye named three quite distinct stages of stress: the initial alarm reaction, the resistance stage and finally exhaustion.

Largely from his work, researchers

have learned that under combinations of stressful conditions, certain changes take place in the bodies of human beings, largely in the nerve and hormone mechanisms. These changes involve the hypothalamus (the area of the brain most involved with emotions) and the pituitary, adrenal and other glands, and may affect most tissues of the body. Also, certain hormones are released that affect the blood pressure. It has been recently shown that cholesterol and uric acid will become elevated during severe stress. And further recent evidence indicates that we have a greater need for Vitamin C when we're under stress.

While initially the secretion of hormones and other changes in the body prepare you to meet the stress of a disturbing situation, during what Selye calls the alarm reaction, these factors become destructive if the stress is continued overlong. The examples of Mary, Joe, Sarah and the Danes suggest some of the events and conditions of life that can bring a person's internal adaptive reactions through the stages of alarm and resistance to exhaustion.

ANIMALS OTHER than those in Dr. Selye's laboratory also give some evidence of the effects of stress. We all know how most wild creatures die in captivity. Even when they are uninjured and are offered food, water, warmth and comfortable cages, few wild rabbits, birds, foxes or deer, for example, can live with the fear and frustration of confinement. And many animals who *can* survive in zoos cannot or will not reproduce.

Heavy attacks on the sensory organs—flickering or glaring lights, say, and loud noise—lead us to believe that too much TV and loud amplification of music can bring on more than visual disturbances or impaired hearing—they can be damaging stress factors. (So can the content of much of television.) Some studies have shown that highly stimulating movies cause a marked elevation in a person's output of adrenalin and other hormones. Some of my patients with low frustration tolerances can't take a terrifying or depressing movie or even read the daily newspaper when they are feeling tense or upset.

Adrenalin is also increased when you participate in sports, of course; it speeds up the heart and increases circulation. But in physical activity the hormone is discharged normally and burned up. Competition is another thing, however, and in some personalities it can be a stress producer. I once had a patient with hypertension whom I had to persuade to give up gin rummy! He and a pal had been playing for years, but we observed that after a game, he had a markedly elevated blood pressure for many hours or even days.

All of us are subjected to some stress in our lives continually, and to large amounts of stress occasionally. Conditioning can help a person cope with stress situations, provided those periods are followed by rest and repair. Many experiments, including Hans Selye's, show that small doses of stress factors, or short periods of severe stress, with sufficient recuperative time in between, can even help build up a resistance to future damage from stress. Dr. Selye's laboratory rats that were subjected to small shocks early in life were able to withstand more stress factors when fully grown than rats that had no alarm situations in infancy. Some parents attempt the impossible and try to provide their children with totally stress-free lives, and then feel guilty when they fail. There is good evidence that if a well-loved child is exposed early to some harsh realities, within reason, they can have a toughening and conditioning effect that equips the child to better cope with life as an adult.

We are living in a very turbulent environment. Besides the national anxiety we all share because of the Vietnam War, inflation, unemployment, civil disturbances, crime, noise, air pollution, water pollution and overcrowding, each person has his own individual stress factors to contend with. Frustration, lack of realization of ideals, and insecurity can be insidious. Just simple loneliness can be harmful; how often has it happened that an older person died within months or a few years of losing a mate? Soldiers in combat suffer terribly from stress; "combat fatigue" is merely a military word for stress. Studies made following World War II indicate that, in many cases, soldiers and prisoners of war suffered from effects of stress for many years after the war—even for the rest of their lives.

WE CANNOT CONTROL all the factors in our lives that cause stress. But if we know what they are, we can avoid some of them—or help someone in our family. Sum up the stress factors in your life—sit down and make a list of them. Separate those over which you have some direct control and balance them against those about which you are relatively powerless. You cannot help your worry over your brother's illness, say, but while you are so concerned about him, you can ease up on other things in your life until that worry situation has passed. Don't commit yourself to more than you can realistically do in your daily life, and don't drive yourself to match someone else's accomplishments. Be practical about your goals—try to forget about those that are unattainable. Especially try not to anticipate trouble that you cannot help—anticipation of problems is often more harmful than trying to cope with them if they do arise.

Eating a balanced diet is one good step toward helping your body cope with stress. Few people realize that overeating puts an enormous strain on the body's adaptive system; similarly, excessive drinking can increase stress. Unless a person has some medical reason not to, moderate exercise is an excellent stress reliever: It helps the body use the hormones and chemicals that have accumulated during periods of tension. Hobbies, vacations and sufficient rest help, too. Having someone to talk to—a clergyman, psychologist, family doctor, even a wise friend—will diminish harmful stress.

It is especially important to recognize and limit your stress factors when your body is already fighting an illness. I believe that almost every disease is aggravated by stress. I once had a diabetic patient whose diabetes went out of control for no apparent reason, until I learned she was in the midst of some deep family trouble. Sir William Osler once said that it is more important to know what sort of patient has a disease than what sort of disease a patient has.

I have had some patients who had to change their jobs to save their lives. Others have helped themselves by changing their life-styles. In a world where we are continually exhorted to buy, spend, go, do, eat, drink and turn on in one way or another, it might be our salvation to learn to simplify, to seek out serenity and to cultivate moderation. To put it simply, cool it.

I think in some ways the current fashion among young people to drop out of what they consider to be the rat race of life and seek simpler ways of living may be a healthy attempt to find a better life-style. Their interest in Eastern religions with the emphasis on meditation, their attempts to live off the land and make things with their hands are a response to a deep need. We might all learn something from what they are attempting to say.

On your list of stress factors are probably a number of situations that would seem to be out of your hands—war, crime, noise, pollution, overcrowding. I believe that unless mankind comes to vastly better terms with his ecology—his social ecology as well as his physical environment—stress may reach epidemic proportions, particularly in our country. Sincere and informed efforts to solve our national problems should be a matter of self-preservation for all of us.

It may seem odd to hear a medical physician speak about such things as love and courage, but in terms of stress, these are two of the most protective qualities to cultivate. While it's true that the ability to love and to be brave are formed early in life, it is also true that sometimes simply by acting, the appropriate emotion will follow. If we are generous and kind toward others, we usually find that we begin to *feel* good toward them. If we behave with courage, even when we are inwardly afraid, we often feel braver for having acted that way. This is not altruism—this is medical advice. ■

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Child Care by Adolescent Parents

by VLADIMIR DE LISSOVOY

Although the results of research in the field of adolescent marriage—including the high risk factor in such marriages—have been given considerable attention recently, surprisingly little information has been published concerning the adolescent parents' expectations of and attitudes toward their children. This article, based on the results of a larger longitudinal study of adolescent marital adjustment over a 3-year period, focuses on the childrearing attitudes and practices of mothers and fathers who married while they were still enrolled in high school. The findings, in terms of the young parents' expectations and attitudes, are disturbing.

Forty-eight couples, all natives of semi-rural areas or small towns in central Pennsylvania, agreed to participate in this study. Of these couples, 46 were expecting a child at the time of their marriage. Forty-one of the wives and 35 of the husbands withdrew from school prior to their graduation.

The girls ranged in age from 15 to 18, with an average age of $16\frac{1}{2}$, while the boys, who were between the ages of $14\frac{1}{2}$ and 19, had an average age of just over 17. According to the last group I.Q. tests administered to them, their scores clustered just above 100.

The families of the couples can be best described as belonging to the rural working class. The fathers were mostly farm owners or tenants and skilled or unskilled laborers. Most of the mothers were homemakers. Although detailed information regarding the parents' education was not obtained, most of the mothers had reached a higher grade in school than their husbands, and more of the mothers were high school graduates.

The young married couples came from families with an average of three children; the girls had two to nine brothers and sisters, with an average of four, while the boys had two to six siblings with an average of three. At the beginning of this study, 12 of the couples lived in a private apartment or house, 21 lived with the wife's family and 15 with the families of the husband.

During the course of the study, each of the couples was visited at least five times. The first visit, to obtain background information and demographic data, was followed by a second about a month later, when the husband and wife were asked to rate themselves according to a marriage adjustment scale. During the third visit—six to nine months later—a brief test of the parents' knowledge of child development was administered. At the fourth visit, made when the first child was between 18 and 30 months old, a childrearing practices schedule, designed to measure only the dimensions of the mothers' acceptance and control of their children, was administered. The final visit was held at the end of the 3-year period.

Because the sample was an atypical one, the results presented here must be noted with caution. Nevertheless, the findings merit the attention of those who work with adolescents in schools or in community agencies.

In general, I found the young parents in this study to be, with a few notable exceptions, an intolerant group—impatient, insensitive, irritable and prone to use physical punishment with their children.

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Only five mothers, for example, expressed enjoyment of their children in the sense that they spontaneously cuddled or played with them just for the sheer joy of it. It was also surprising to learn that in this primarily rural area only three mothers had attempted to breastfeed their children.

There is little question that these young parents were undergoing severe frustrations. Their lack of knowledge and experience, their unrealistic expectations of child development, their general disappointment in their lives and their lack of economic resources served to raise their irritability and lower their threshold of tolerance.

It is evident that the young parents were not familiar with developmental norms . .

The following results are based upon the data gathered specifically in regard to the children by means of interviews, self-rating scales, objective tests and clinical notes taken during and immediately after each visit.

Because developmental norms are often suggested as guidelines for expected behavior, parents' conceptions of child development often govern their reactions to their child. To measure the young parents' knowledge of some very basic norms, several questions were presented separately to the mothers and fathers during one visit. At this point nearly all the couples had had their child, and seven couples had children between six and nine months of age.

The questions required an answer stating only the age, in weeks, months or years, at which the parents expected their child to demonstrate certain behavior. One question, for example, asked, "How old do you think most babies are when they can sit alone without any support?" In this way answers were elicited for the parents' expectations of the ages at which babies might smile, take their first step, speak their first word, and achieve other selected patterns of behavior. The questions and the parents' responses for each area of development are shown in the table below.

It is evident that the young parents were not familiar with developmental norms. Only in their expectations of the first appearance of the social smile did three mothers and four fathers mention a realistic norm.

When, for purposes of comparison, the same questions were posed to a group of unmarried seniors attending a rural high school, the response scores of the boys and girls in this group, who were approximately the same age as the young parents, were almost identical.

To note the parents' ideas concerning how often their babies could be expected to cry, we posed the question: "Let's say the baby is fed and dry. How much crying can you expect from him or her for almost no reason?" The parents were given four choices of answers:

Should not cry at all;

Very little crying, but then only if he wants anything;

AGES AT WHICH PARENTS EXPECTED BABIES TO ACHIEVE SELECTED PATTERNS OF BEHAVIOR

Area of development and approximate norm in weeks		Parents' Estimates in Weeks	
		Mothers	Fathers
Social Smile	(6)	3	3
Sit alone	(28)	12	6
Pull up to standing	(44)	24	20
First step alone	(60)	40	40
Toilet training (wetting)		24	24
Toilet training (bowel)		26	24
First word	(52)	32	24
Obedience training		36	26
Recognition of wrong doing		52	40

Maybe it depends on the baby—some cry more than others;

You can expect a lot of crying.

While 67.4 percent of the mothers recognized the fact that some babies cry more than others, or realized that one can expect a lot of crying, only 39.7 percent of the fathers selected these answers. What is important to note here is that almost one-third of the mothers' responses and almost two-thirds of the fathers' suggested an attitude of low tolerance toward their baby's crying. This low tolerance, combined with unrealistic expectations of development, contributed to their impatience with their children—and to their sometimes cruel treatment of them. In fact, during a number of visits parents freely discussed how they spanked their babies for crying or for other "misdeeds" and on several occasions I witnessed such punishment by different couples.

MEASURING ATTITUDES

Thirty-one mothers were interviewed to assess their acceptance of their children and the control they exercised in dealing with them. At this time 17 of the mothers had one child and eight of these were expecting another. The other 14 mothers already had two children and three were again pregnant.

Of the questions used for this part of the study, 22 were rated to determine the acceptance dimension and 16 the control dimension. The mothers' answers, set down verbatim when possible, were transcribed and rated independently by two advanced graduate students.

One of the questions, for example, was designed to measure the mother's general attitude toward her child in regard to feeding and the manner in which she handled feeding problems. She was asked: "Can you tell me something about Danny's food likes and dislikes? How do you get him to eat the things that are good for him but which he does not like?"

Her answers were rated on a 5-point scale with three points on the scale defined as follows:

☐ Evidence of tension and irritability in the handling of feeding problems. Appears unresponsive to the needs of the child.

☐ Conscientious desire to make certain that the child gets the right food. Mild pressure, such as talking to the child, telling stories while feeding him, disguising food and otherwise making certain that he gets enough of the right food.

☐ Easy going and child-centered in her manner. Understands individual differences in appetite and recognizes the child's right to food preferences. Methods of feeding reflect warmth of attitude.

Only five of the mothers spontaneously cuddled or played with their children just for the sheer joy of it . . .

The mothers' acceptance scores on the series of questions clustered around the lower end of the 5-point rating scale—the mean rating was 2.47—while their control scores averaged 3.29, just over mid-point toward the high end of the scale. Additional statistical information on the mothers' attitudes concerning acceptance and control is available from the author.[1]

CARING FOR CHILDREN

Caring for their children proved to be a trying experience for the majority of the couples in this study. Although the couples' parents were helpful in many ways—primarily in helping the couples achieve marital stability—they were not very effective in helping them cope with their children. The couples' parents apparently believed that raising children is "doing what comes naturally," and frequently told the young parents, "You'll find out soon enough" when they were asked specific questions. Their "advice" stressed the importance of success in early toilet training, being strict to insure that the child would "mind," and letting the baby "cry it out" so it would not be spoiled.

While collecting this data I was asked a variety of questions by the young parents. In order to minimize personal involvement, these questions were parried by saying a discussion would be forthcoming at a later session. However, in the light of some of the cruel acts toward children I witnessed, this was an especially difficult thing to do and in two cases all semblance of objectivity was abandoned in the interest of protecting the child from harsh punishment.

During one visit, for instance, a 6-month-old infant had been crying very hard for some time and, at my suggestion, the mother brought the child into the living room. The baby screamed and thrashed furiously as the mother held it on her lap. Then the baby arched and appeared to hit the back of its head against the mother. When these actions were repeated and the mother had twice slapped the baby on the cheek and shaken it very hard, I asked her to give me the baby. I cuddled and comforted the infant. After a few minutes, the baby's more furious actions subsided and the child, apparently exhausted, went to sleep. I informed the mother rather directly that hitting a distressed baby would not stop its crying and that permanent damage could result from such actions.

During another visit, a young father spanked a 7-month-old baby who had apparently pulled the nipple from his bottle and spilled the contents in his crib. Here again I intervened, stressing the possible damage which could result from physically punishing the infant. Although I pointed out that the bottle was probably spilled because the nipple was not put in correctly, the father said, "He has been asking for this all day." In this particular case the mother worked afternoons and did not return home until early in the evening. Obviously, coping with the baby's daily demands was a difficult task for this young father.

According to the parents' statements, such physical punishment as spanking and slapping a child's wrist, hand or face were common practices after the child started to crawl. When asked what type of discipline they used to prevent children's marking on walls, jumping on furniture, hurting bric-a-brac and climbing out of the crib, 80 percent of the mothers mentioned physical punishment as a means of control.

To the question, "How often do you spank?," the mothers' replies included, "When he deserves it," "It depends on what he has done," and "When I can't take it any longer." Virtually all of the mothers gave an answer that could be interpreted that their children were so punished, and all but two mothers said their husbands also spanked the children.

We must conclude that experience with younger brothers or sisters—and occasional baby-sitting jobs—had not helped these parents understand how a child develops or that much knowledge and patience are required for raising children. In addition, when the young parents turned to their families for advice, the help they received was limited.

Neither was much help offered by their physicians. What advice was given usually came in the form of mimeographed directions indicating formulas for feeding, the times to introduce certain foods and food supplements, and the schedules for future visits to the physician. These items were usually distributed by the doctor's nurse.

Caring for their children proved to be a trying experience for the majority of the couples . . .

In measuring maternal attitudes, I used a questionnaire based upon questions utilized in an earlier study conducted by R. R. Sears, E. E. Maccoby and H. Levin.[2] Their investigation of childrearing practices among a younger group of mothers led them to similar conclusions in regard to the young mothers' impatience and irritability with their children.

Obviously, a realistic approach to helping young people become effective parents is necessary. One major national step in this direction is the Education for Parenthood program described in the special March-April 1973 issue of this journal. A joint Office of Education-Office of Child Development effort, it is designed to help teenage boys and girls across the nation prepare for parenthood by learning about child development and family relationships—not only in class, but also through working with young children.

Another major effort on the national level is being undertaken by the Consortium on Early Childbearing and Childrearing, Child Welfare League of America, Inc. The Consortium's activities to help communities throughout the United States develop and improve services for school-age pregnant girls, the young fathers and their children, also are described in that issue (see "School-Age Parents" by Shirley A. Nelson).

However, the restrictive and sometimes punitive behavior of the young parents described here was due not only to ignorance or lack of experience. The parents' personal, social and economic frustrations, which contributed to disenchantment in their marriage relationships, also affected their behavior toward their children. Personal counseling, through community social service agencies or through adult education classes, could help them resolve many of these frustrations and, as another result, improve their childrearing practices. Such resources should be made available to adolescents. Public health nurses also should be encouraged to visit periodically the young families in their community.

It is my conclusion that the children of many adolescent marriages have a high risk of joining the number of battered and abused babies; any measures to help prevent this deserve serious consideration. ■

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[1] Statistical information can be obtained by writing Dr. Vladimir de Lissovoy, Professor of Child Development and Family Relationships, College of Human Development, The Pennsylvania State University, University Park, Pa. 16802.

[2] Sears, R. R., Maccoby, E. E. and Levin, H., *Patterns of Child Rearing*, Evanston, Ill.: Row, Peterson & Co., 1957.

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Mom and Dad

By August Gribbin

AMERICANS make lousy parents. It shows in the way their lousy kids are wrecking society. A lot of ordinary citizens and some experts on the American family would agree with this sweeping generalization. Some extremists even recommend that couples should get permits before they are allowed to have children.

Many middle-class Americans read books and take courses to improve as parents. Yet few give much thought to how they will rear youngsters *before* they start having them. They rarely consider the adverse impact that child rearing frequently has on marriages, and they commonly produce offspring for inappropriate reasons.

Bored Malcontents

The behaviorists who level the above allegations add that Americans typically are bewildered and exasperated by "parenting," which they find tedious to say the least. That's important, these critics say, because unsure parents can confuse their children and engender the kind of maladjustment that's partly responsible for the huge bunch of bored malcontents who seem bent on venting their spleens on their parents and on society.

This summer a group of psychiatrists, psychologists, pediatricians, educators, social workers, sociologists, and others met in Philadelphia to talk about all this. Formally they were to discuss whether the family as we've known it can survive. They came to no conclusion on that.

They did isolate some of the causes for the cracks in the institution of the family. Poor parenting was one. Their discussions provided a composite view of current ideas for countering the effects of poor child rearing and corrected some common misconceptions of what parents must do to raise happy, self-sufficient, and achieving youngsters.

But the professionals' ivory-tower synthesis lacked the comment of the accused—the parents and would-be parents. In seeking those comments, The Observer turned to more than 60 parents, single persons, and expectant parents from such diverse places as Baltimore; Boston; Columbia, S.C.; Denver; Ephrata, Wash.; Hillandale, Md.; Los Angeles; Minneapolis; New York City; Port Isabel, Texas; Schenectady, N.Y.; and Washington, D.C.

Underrated Demands

These interviewees generally agreed with the accusers, as did other authorities interviewed. They noted, for instance, that parents-to-be tend to underrate the physical and psychic energy that child rearing demands. They said that although being a parent is one of the most significant things people can do, they tend to devote less time preparing for it than to obtaining a driver's license. They agreed that typically even young parents have lost contact with youngsters and have forgotten what children are like by the time they have their own offspring.

Listen to what some interviewees said—

About confusion:

"They used to warn, 'Spare the rod and spoil the child.' Then they urged: 'Spare the rod! Spoil the child!' Now? Zillions of theories. What do you do?"

"The kid arrives like a new bike, and parents just have to sit down and figure out how to put it together."

"Society doesn't prepare young people for child rearing. It's overromanticized."

About tedium:

"Once the kid comes, you're never able to do anything on the spur of the moment: Everything's a production—there's no more love in the afternoon." "I take kids to soccer camp and swimming lessons, do wash, clean a house that's a horrid mess because rain kept the kids inside. Dull stuff. I *feel* dull, like I don't *do* a damn thing."

About exasperation:

"There aren't any realistic child-rearing mod-

Please Turn to Page 18, Column 1

cis; there weren't any 15 years ago. You had Doris Day and the lady who cleaned her floor on TV. You *always*, *always* felt inadequate."

"Being a mother has lost prestige; sometimes I feel even my husband doesn't think I'm as worth-while any more."

"I resent this baby and the changes it's bringing to my marriage. Yet I love her; I planned for her."

"The other day my husband said he never wanted four kids. He'd grown up in a big family and despised it. Now he's got four teen-agers. He says they crowd him; he hates it."

A Discouraging Picture

Then there's the 30-year-old Boston businesswoman who recalls that her parents seemed frustrated by child rearing. She remarks: "One of my fondest memories—now—is of my mother saying, 'Be happy, dammit, or I'll beat the hell out of you!'"

Urie Bronfenbrenner, professor of human development and family studies at Cornell University, declares that when child-rearing problems impact unfavorably on the child, the first symptoms are "emotional and motivational: disaffection, indifference, irresponsibility, and inability to follow through in activities requiring application and persistence [followed by] antisocial acts injurious to the child and society."

Translate the generalities to specifics and multiply them, and, as Bronfenbrenner points out, you get this sort of picture:

There's a birth in the nation every 10 seconds; a serious crime every 4. Overall, juveniles commit 30 per cent of those grave crimes. In suburbia they commit 35.2 per cent.

Nearly a million predominantly middle-class youth run away from home each year. About the same number of young people drop out of high school; that's a fourth of all who start.

Parents' Attitudes Important

Drug and especially alcohol abuse among the young is increasing again. Vandalism is at a new high. The number of suicides by youths aged 15 to 24 years old has gone from 2.7 per 100,000 in 1950 to 10.9 per 100,000 in 1973. Divorces have tied the U.S. record at 4.6 per 1,000. There were 970,000 divorces in 1974. There now are 8.5 million children living in single-parent families.

Sarane Spence Boocock, a sociologist at New York City's Russell Sage Foundation and a visiting associate professor at Yale University, has reported some reasons why these things occur. She has spotlighted issues that can lead to parental attitudes that dilute or distort their child-rearing efforts.

For example, she says, society accords career women high respect but at times denies it to stay-at-home mothers. So it's fairly common, psychiatrists and other clinicians say, for women to become resentful of status loss after forfeiting careers and having children. It's also typical for married career women's childlessness to prompt snide remarks.

A municipal employe living in suburbia says: "I finally started lying. Told neighbors and others that I couldn't have kids. Then they started pitying my 'handicap,' which was almost as insufferable as their needling me about the 'selfishness' of not being a mother."

Yet stay-at-home mothers feel criticism too. A 31-year-old divorcee and mother of three says: "At parties people ask me what I do. When I say I keep house for my children, they act like *I do nothing* and that I am nothing. It's embarrassing; sometimes I lie too."

Partly because of this quandary, Boocock concludes that no transition "in our society today [is] as stressful as the transition to motherhood." But there's another big cause of stress: *fathers*.

Many argue that because mothers lack the aid they formerly got from others in their homes, fathers nowadays must help significantly with the children. In fact, many have assumed that there's a trend toward dads helping with the kids because so many young women stridently proclaim they shouldn't—or won't—be solely responsible for day-to-day child care, and because so many men at least pay lip service to the notion.

Not so, says Boocock. "The father role is not being filled in many families by the biological father or any other male." (Mothers questioned by The Observer generally agreed—and vigorously.) Bronfenbrenner quotes reports revealing that although middle-class fathers asserted in interviews that they spent "an average of 12 to 20 minutes a day playing with their 1-year-old infants," actual observation showed they spent an average of 37.7 *seconds* per day "interacting" with their babies in any way.

Scale of Dissatisfaction

On another matter Observer interviewees typically declared that rearing children tends to improve good marriages but wrecks shaky ones. But according to Boocock, "Data . . . show rather consistently that the presence of children has a negative rather than positive effect upon husband-wife relationships." She says childless couples report "greater marital satisfaction" than parents and that parents' reported dissatisfaction increases with the number of children they have.

Students of family life now are questioning people's motives for becoming parents, Boocock says. Frequently they find the motives "not conducive to the welfare of children."

If it's best for children that parents opt to have them out of love and a conviction that they can rear happy, achieving offspring, it's also the rarest reason given, behaviorists say. The Observer's admittedly small and unscientific sampling backs the conclusion.

Reasons for Children

For while minimizing child rearing's unpleasantries, interviewees commonly said they wanted—or had wanted—"the joy of children" or wished to "perpetuate themselves," "carry on the family name," or "fulfill themselves." Some said they "feared missing out on something," "felt having children was expected," or "just did it without much thought." One collegian said he wanted children "because living for someone else is what makes life complete"; several mothers said they "liked children."

And then there's the confusion that child rearing purportedly causes. Mrs. George Rivera of Port Isabel, Texas, has this typical view: "Methods our parents and grandparents used to cope and raise children, we're told, are no longer valid; yet the new methods of experts aren't working. . . . [Parents] are lied to, cheated, made fun of on TV, exposed to so many conflicting theories . . . that we're confused, we've lost self-respect, and we even listen to the kids' advice—we don't trust our own instincts."

In an interview, psychologist John Girdner, associate professor at Union College, Schenectady, N.Y., traces the confusion to many things, including the loss of the religious base that once largely influenced people's relationships with children. But the social sciences have complicated the problem, he says, because so-called experts "have been ladling out information, and one doesn't know if it's much damn good."

Parents Look for Help

Nonetheless, parents look to books and courses for help. The current volume of *Books in Print* lists some 150 titles on child rearing. Sales of physician Benjamin Spock's first book, *Baby and Child Care*, have exceeded 24 million copies. Sales of the late Haim Ginott's *Between Parent and Child* have reached 500,000, and Rudolf Dreikurs' *Children: The Challenge* has sold 300,000 copies.

More than 200,000 parents have paid $50 to $65 each to attend the relatively new Parent Effectiveness Training courses created by clinical psychologist Tom Gordon of Solana Beach, Calif. The courses, given by some 7,000 trained instructors across the country, attempt to help parents apply in child rearing such venerable therapeutic skills as "active listening," handling confrontations, problem solving, and the like. Gordon's $4.95 course text, *Parent Effectiveness Training*, has sold 500,000 copies.

A Lack of Programs

There are private associations such as the Child Study Association of America Well-Met Inc., which, among other things, publishes and disseminates books and pamphlets about parenting and child problems. Still, authorities say there's no effective educational program for people to understand parenthood's demands before becoming parents.

To try to fill the need, the U.S. Office of Child Development has produced, as part of a comparatively small, $4.2-million effort, a one-year high school curriculum on parenting. It's also being offered as an optional course to schools, the Boy Scouts, 4-H clubs, and the like. Currently 648 public and private schools, 102 colleges and universities, and 134 social agencies and hospitals utilize the course and its materials.

There are suggestions for other action. Among them, says Bettye Caldwell, professor of education at the University of Arkansas, are proposals for mandatory "preparenting training" and for requiring "parenting licenses" before a couple could have a child legally. If a parenting license smacks of Orwell's *1984*, well, it's also a sign of the depth of some people's concern.

Common but Perhaps Wrong

Baltimore's National Organization for Non-Parents (NON) is one group suggesting parent licenses. Carol Goldman, its executive director, says NON has done so mainly to publicize the idea that having children can be irresponsible. Parenting is so important that would-be parents should have to justify their decision to have children, she says, and nonparents shouldn't have to justify their decision not to.

It's a common American belief that to bring up a child, parents and teachers must, as Jerome Kagan puts it, "praise, punish, and posture at the right time with proper enthusiasm—like the conducting of a major symphony." That's wrong, says Kagan, professor of social relations at Harvard.

Parents do not have the definitive role in child rearing, and the child's character is not immutably formed in its early years, says Kagan. Friends and teachers also mold him. A child's requirements change, he asserts, and the parent-programed "tapes" of the child's character aren't "nonerasable." "Experiences during later childhood [are perhaps] even more influential than the maternal treatments experienced during the first three years."

A Need for Standards

Children do have psychological needs, Kagan notes. He says one is the need for consistent standards. The standards themselves are "less critical than the fact of knowing that what is wrong and what is right remain constant . . . [for] a child is made uncertain by . . . being punished for fighting on Monday but jokingly teased for the same violation on Wednesday."

How should parents go about rearing children who will have what Kagan terms the qualities that our society demands of well-adjusted children a sense of worth; autonomy in personal decision-making; the ability to decide conflicts for himself; heterosexual success; and personal competence?

Kagan has no magic formula—and in fact few behaviorists are willing to give general advice on child rearing. But Girdner, the Union College psychologist, says: "The No. 1 principle is for parents to know where they are—to know themselves. It's hard. It's hard for young parents at 18 or 21 years old to understand themselves when they're in misery from a bad home situation or when they're feeling like superbeings with the world at their feet."

Girdner has another thought for prospective parents: "Remember that you probably aren't going to get much satisfaction or self-fulfilment or joy with parenting. So be realistic."

III. THE EPISODE OF CHILD MALTREATMENT (III.13)

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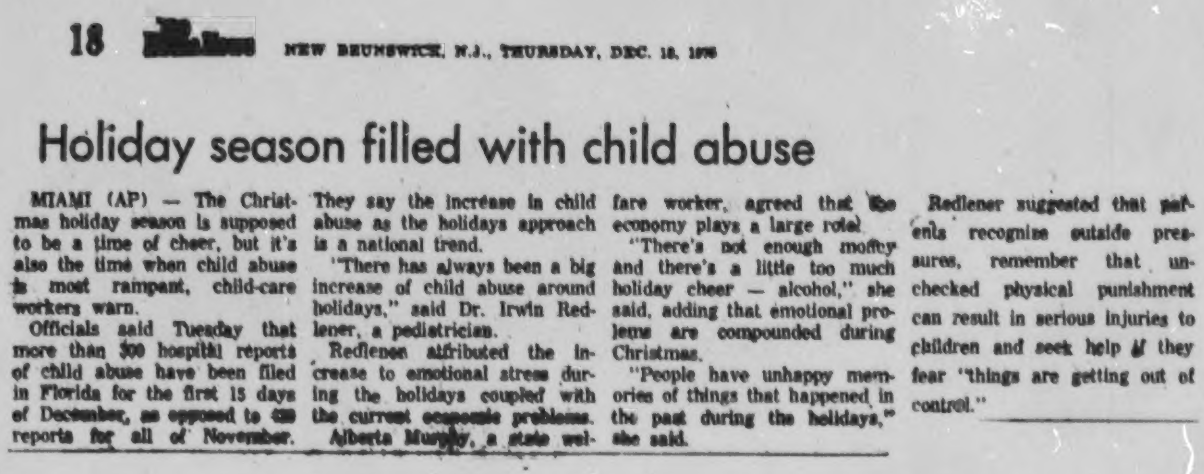


18 [illegible] NEW BRUNSWICK, N.J., THURSDAY, DEC. 18, [illegible]

Holiday season filled with child abuse

MIAMI (AP) — The Christmas holiday season is supposed to be a time of cheer, but it's also the time when child abuse is most rampant, child-care workers warn.

Officials said Tuesday that more than 300 hospital reports of child abuse have been filed in Florida for the first 15 days of December, as opposed to [illegible] reports for all of November.

They say the increase in child abuse as the holidays approach is a national trend.

"There has always been a big increase of child abuse around holidays," said Dr. Irwin Redlener, a pediatrician.

Redlener attributed the increase to emotional stress during the holidays coupled with the current economic problems.

Alberta Murphy, a state welfare worker, agreed that the economy plays a large role.

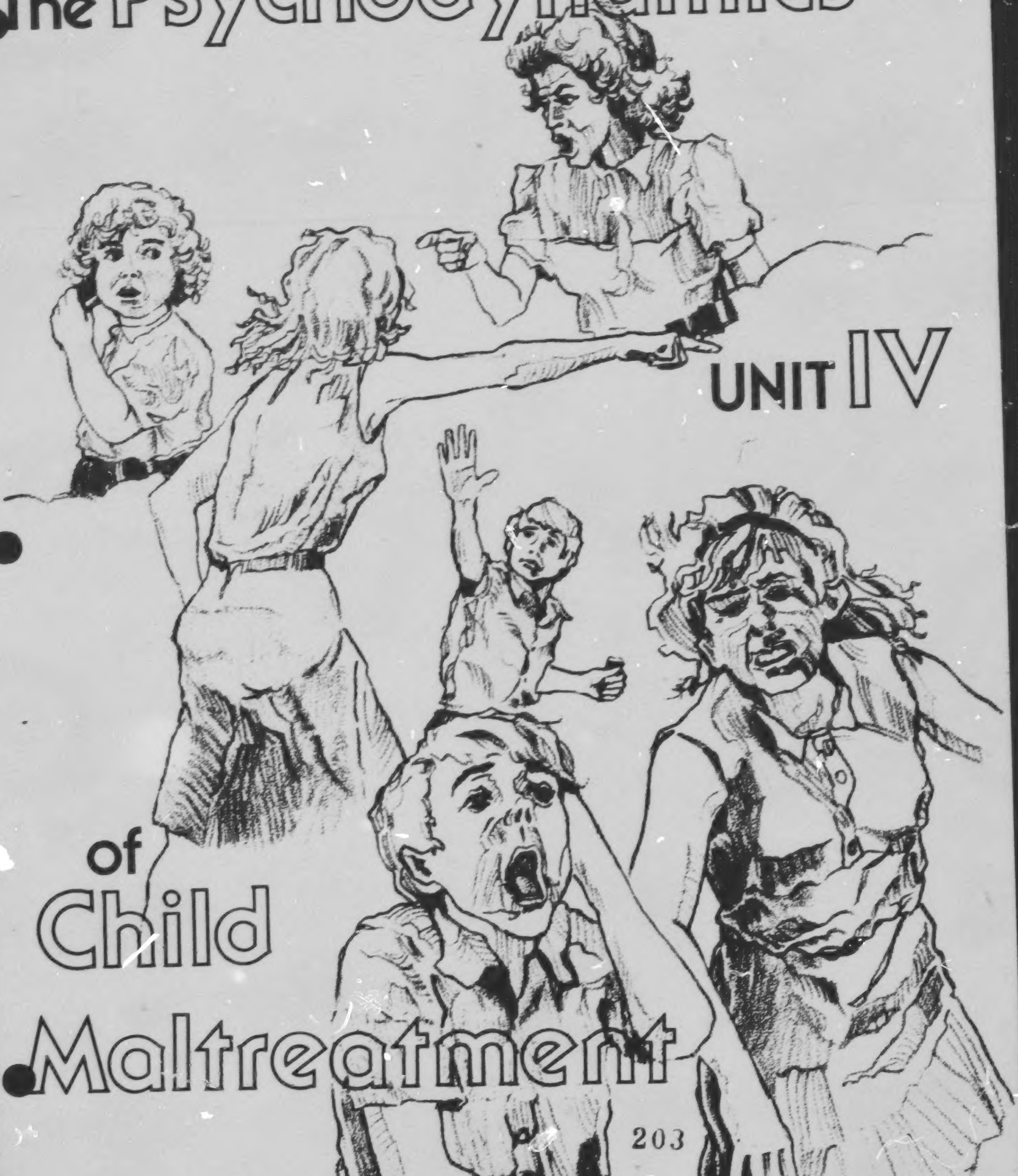
"There's not enough money and there's a little too much holiday cheer — alcohol," she said, adding that emotional problems are compounded during Christmas.

"People have unhappy memories of things that happened in the past during the holidays," she said.

Redlener suggested that parents recognize outside pressures, remember that unchecked physical punishment can result in serious injuries to children and seek help if they fear "things are getting out of control."

The Psychodynamics of Child Maltreatment

UNIT IV



IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

--- Why Do They Do It?

UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective

THE STUDENT WILL BE ABLE TO EXPLAIN THE PSYCHODYNAMIC DIMENSION OF CHILD MALTREATMENT.

Generalizations for Unit IV.

A. Child maltreatment is attributed to the psychodynamic interaction among the caretaker, the child, and the stress factor or stressor.

B. The psychodynamic dimension of child maltreatment may be measured by the caretaker's conscious and/or unconscious actions or reactions to the child.

C. The psychodynamic dimension of child maltreatment may be measured by the child's conscious and/or unconscious actions or reactions to the caretaker (i.e., to maltreatment).

D. The psychodynamic dimension of child maltreatment may be measured in the recurring pattern or cycle of abuse and neglect within the same family from one generation to the next.

Performance Objectives for Unit IV

1. STATE the meaning of the term psychodynamics.
2. STATE the meaning of the term interaction.
3. EXPLAIN psychodynamic interaction in relation to stress factors within society, the family, and the individual.
4. STATE the meaning of the term conscious (re)actions in relation to the caretaker.
5. STATE the meaning of the term unconscious (re)actions in relation to the caretaker.
6. DESCRIBE typical (re)actions of the caretaker to the child.

7. DISCRIMINATE conscious and unconscious (re)actions of the caretaker to the child.
8. EXPLAIN the relationship of stress to the conscious and unconscious (re)actions of the caretaker to the child.
9. STATE the meaning of the term conscious (re)actions in relation to the child.
10. STATE the meaning of the term unconscious (re)actions in relation to the child.
11. DESCRIBE typical reactions of the child to the caretaker.
12. DISCRIMINATE conscious and unconscious (re)actions of the child to the caretaker.
13. EXPLAIN the relationship of stress to the conscious and unconscious (re)actions of the child to the caretaker (i.e., to maltreatment).
14. EXPLAIN the relationship of nurturing experiences in infancy or childhood to the ability to nurture in later life.
15. EXPLAIN the relationship of conditioning toward violence in infancy or childhood to violent behavior in later life.
16. RECOMMEND ways to break the recurring cycle of child maltreatment from the standpoint of the child.
17. RECOMMEND ways to break the recurring cycle of child maltreatment from the standpoint of the caretaker.

UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective

The student will be able to explain the psychodynamic dimension of child maltreatment.

Performance Objectives for Generalization A

1. STATE the meaning of the term psychodynamics.
2. STATE the meaning of the term interaction.
3. EXPLAIN psychodynamic interaction in relation to stress factors within society, within the family, and within the individual.

Generalization A

CHILD MALTREATMENT IS ATTRIBUTED TO PSYCHODYNAMIC INTERACTION AMONG THE CARETAKER, THE CHILD, AND THE STRESS FACTOR OR STRESSOR.

Sample Content

1. *The definition of psychodynamics: 1: the psychology of mental or emotional forces or processes developing esp. in early childhood and their effects on behavior and mental states 2: explanation or interpretation (as of behavior or mental states) in terms of mental or emotional forces or processes 3: motivational forces acting esp. at the unconscious level
2. Interaction viewed as an action (or reaction) in response to an influence, an event, or a person (past or present)
3. Psychodynamic interaction viewed as action (or reaction) of the child or the caretaker in response to:
   - a) An influence or influences (past or present)
   - b) An event or events (past or present)
   - c) A person or persons (past or present)

---

* Webster's New Collegiate Dictionary, 1974.

4. Psychodynamic interaction between the child and the caretaker viewed in relation to stress --
    a) Within society
    b) Within the family
    c) Within the individual

Suggested Classroom Activities and Procedures for Performance Objectives A 1, 2, and 3

1. Prepare students with a brief review of I B Sample Content 1 through 3, and III A Sample Content 1 through 3.
2. Write Psychological Evidence of Child Maltreatment Today (Generalization I B Sample Content 4) on board.
3. Review I C Sample Content 3 (Suggested areas of dysfunction within the individual) and III.3 Characteristics of the Potentially Abusive or Neglectful Caretaker.
4. Introduce Generalization IV A and write on board for students.
5. Clarify student understanding of definition of terms for Unit IV (IV.1).
6. Review III A and restate IV A Sample Content 1 for each in terms of the mental or emotional forces or processes which take place:
    a) Between the caretaker and the stress factor ("triggering" mechanism)
    b) Between the caretaker and the child
    c) Between the child and the caretaker (maltreatment)
7. Discuss the meaning of the term interaction (IV.1) as a mutual or reciprocal action or influence.
8. Suggest to students that psychodynamic interaction may be viewed as action or reaction by the caretaker or the child in response to:

a) An influence or influences (past or present)

b) An event or events (past or present)

c) A person or persons (past or present)

9. Refer once more to I C Sample Content 3 b) Psychological (emotional) incapacity or inability; and relate it to the inability to cope with stress as a characteristic of the potentially abusive or neglectful caretaker. See III.3.

10. Have students relate psychodynamic interaction to the following:

I C The phenomenon of child maltreatment is ascribed to be the symptom of a dysfunction within society, the family, or the individual which manifests itself when a child is physically or psychologically damaged.

III.3 Characteristics of the Potentially Abusive or Neglectful Caretaker

III.5 Characteristics of the Potentially Vulnerable Child

II.9 Typical Manifestations of Psychological Abuse and Neglect in the Child

III E Stress, the "triggering" mechanism, may originate within society, the family, or the individual

11. Develop student understanding of psychodynamic interaction as action or reaction on the part of the caretaker or the child in response to stress, the "triggering" mechanism, which may be:

a) A past or present influence (or influences) originating --

(1) Within society
(2) Within the family
(3) Within the individual (caretaker or child)

b) A past or present event (or events) originating --

  (1) Within society

  (2) Within the family

  (3) Within the individual (caretaker or child)

c) A past or present person (or persons) originating --

  (1) Within society

  (2) Within the family

  (3) Within the individual (caretaker or child)

12. Students may:

  . Roundtable discuss psychodynamic interaction in relation to child-rearing practices as customs or tradition. See II C.

13. Conclude with assessment measures for Performance Objectives 1, 2, and 3.

UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective

The student will be able to explain the psychodynamic dimension of child maltreatment.

Performance Objectives for Generalization B

4. STATE the meaning of the term conscious (re)actions in relation to the caretaker.
5. STATE the meaning of the term unconscious (re)actions in relation to the caretaker.
6. DESCRIBE typical (re)actions of the caretaker to the child.
7. DISCRIMINATE conscious and unconscious (re)actions of the caretaker to the child.
8. EXPLAIN the relationship of stress to the conscious and unconscious (re)actions of the caretaker to the child.

Generalization B

THE PSYCHODYNAMIC DIMENSION OF CHILD MALTREATMENT MAY BE MEASURED BY THE CARETAKER'S CONSCIOUS AND/OR UNCONSCIOUS ACTIONS OR REACTIONS TO THE CHILD.

Sample Content

1. Conscious (re)actions viewed as (re)actions of the caretaker which are aware, deliberate, planned
2. Unconscious (re)actions viewed as (re)actions of the caretaker which are not consciously realized, planned, or done
3. Conscious and unconscious (re)actions of the caretaker in relation to stress

4. Typical conscious and unconscious (re)actions of the caretaker to the child:

   a) Expects (demands) the child to perform above his/her physical, emotional, or intellectual capacity
   b) Uses the child as an object of aggression in order to discharge hostility toward another; i.e., as a "pawn"
   c) Depends upon the child to fulfill the emotional or physical needs of the caretaker, unrelated to or disregarding the child's own needs
   d) Attributes to the child inappropriate or adult feelings and capabilities
   e) Ascribes to the child the guilt feelings of the caretaker; i.e., uses the child as a "scapegoat"
   f) Views the child as a competitor or a burden
   g) Perceives the child as unloveable without apparent reason
   h) Identifies the child with self or some other hated person
   i) Associates the child with unpleasant experiences
   j) See Typical Acts of Physical and Psychological Abuse (II.4)
   k) See Typical Acts of Psychological Abuse Without Physical Abuse (II.5)
   l) See Typical Acts of Physical and Psychological Neglect (II.6)

UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Suggested Classroom Activities and Procedures for Performance Objectives 4 through 8

1. Prepare students for an understanding of Generalization IV B by a thorough review of III A Sample Content 1 through 3, and IV A Sample Content 1 through 4.
2. Introduce Generalization IV B, and write on board for students.
3. Clarify student understanding of the terms conscious (re)action and unconscious (re)action (IV.1).
4. Review student understanding of III C.
5. Discuss IV B Sample Content 1 and 2 in relation to III E, III.6, and III.7
    a) The caretaker's conscious (re)action to stress
    b) The caretaker's unconscious (re)action to stress
6. Review III E, III.6, and III.7 in relation to the following:
    a) Typical Acts of Physical and Psychological Abuse (II.4)
    b) Typical Acts of Psychological Abuse Without Physical Abuse (II.5)
    c) Typical Acts of Physical and Psychological Neglect (II.6)
7. Have students react to selected examples from the above as:
    a) Conscious acts of child maltreatment
    b) Unconscious acts of child maltreatment
    c) Conscious or unconscious (re)actions to stress
8. Show Transparency 19.
9. Have students react to selected examples from IV B Sample Content 4 as:
    a) Conscious acts of child maltreatment
    b) Unconscious acts of child maltreatment
    c) Conscious or unconscious (re)actions to stress

10. Review IV B Sample Content 1 through 4 in relation to III D.

    a) Refer students to Characteristics of the Potentially Vulnerable Child (III.5).

    b) Correlate with Typical Manifestations of Psychological Abuse and Neglect in the Child (II.9).

    c) Discuss the child as the stress factor.

11. Students may

    - Roundtable discuss psychodynamic interaction in relation to typical conscious and unconscious reactions of the caretaker to the child (IV.3).
    - Write a brief paper on typical conscious and unconscious reactions of the caretaker to the child in relation to child-rearing practices as custom or tradition (II C).
    - Utilize selected case histories from Unit II for examples of psychodynamic interaction between the caretaker and the child.
    - View and analyze the film War of the Eggs in relation to the psychodynamic dimension of child maltreatment.
    - View and discuss the film Rockabye Baby in relation to nurturing in infancy and young childhood and ability to nurture in later life.

12. Conclude with assessment measures for Performance Objectives 4 through 8.

UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective

The student will be able to explain the psychodynamic dimension of child maltreatment.

Performance Objectives for Generalization C

9. STATE the meaning of the term conscious (re)actions in relation to the child.
10. STATE the meaning of the term unconscious (re)actions in relation to the child.
11. DESCRIBE typical reactions of the child to the caretaker.
12. DISCRIMINATE conscious and unconscious reactions of the child to the caretaker.
13. EXPLAIN the relationship of stress to the conscious and unconscious reactions of the child to the caretaker (i.e., to maltreatment).

Generalization C

THE PSYCHODYNAMIC DIMENSION OF CHILD MALTREATMENT MAY BE MEASURED BY THE CHILD'S CONSCIOUS AND UNCONSCIOUS REACTIONS TO THE CARETAKER (i.e., TO MALTREATMENT).

Sample Content

1. Conscious reactions viewed as (re)actions of the child which are deliberate, planned, aware
2. Unconscious reactions viewed as (re)actions of the child which are not consciously realized, planned, or done
3. Conscious and unconscious (re)actions of the child to the caretaker in relation to stress; i.e., maltreatment

4. *Typical conscious and unconscious (re)actions of the child to the caretaker (i.e., to maltreatment)

Disturbed eating habits; i.e., irregular, too much, too little

Nightmares

Bedwetting

Extreme passivity

Extreme aggressiveness

Anti-social behavior; e.g., stealing, fire-setting, addiction, violence

Apathy and withdrawal

Infantile behavior; e.g., infantile speech, thumbsucking

Stuttering

Loss of speech

Growth retardation

Mental retardation

Academic failure

Temper tantrums

Social retardation

Delayed motor development

Hypersensitivity (auditory and/or visual)

Sadomasochistic behavior

Failure-to-thrive

Abnormal Fears

NOTE: Similar manifestations may arise from other causes.

* SEE: Typical Manifestations of Psychological Abuse and Neglect in the Child (II.9)

Suggested Classroom Activities and Procedures for Performance Objectives 9 through 13

1. Prepare students for an understanding of Generalization IV C by a review of III A Sample Content 1 through 3, and IV A Sample Content 1 through 4.
2. Introduce Generalization IV C, and write on board for students.
3. Clarify student understanding of the terms conscious and unconscious (re)actions (IV.1).
4. Review student understanding of III D.
5. Discuss IV C Sample Content 1 and 2 in relation to III E and II.7:
   a) The child's conscious (re)action to stress
   b) The child's unconscious (re)action to stress
6. Refer students to Typical Manifestations of Psychological Abuse and Neglect in the Child (II.9) for examples of:
   a) A Conscious reaction of the child to maltreatment
   b) An unconscious reaction of the child to maltreatment
   c) As both
7. Show Transparency 20 a, b, and c; and discuss the psychological manifestations of abuse and neglect in the child in relation to the physical manifestations of abuse and neglect in the child. See II.8.
8. Differentiate, where possible, examples of the following:
   a) A conscious physical reaction of the child to maltreatment
   b) An unconscious physical reaction of the child to maltreatment
   c) A conscious psychological reaction of the child to maltreatment
   d) An unconscious psychological reaction of the child to maltreatment

9. Review IV C Sample Content 1 through 4, in relation to III C.
   a) Refer students to Characteristics of the Potentially Abusive or Neglectful Caretaker (III.3).
   b) Refer to III D Sample Content 3 Characteristics of the potentially vulnerable child from the viewpoint of the caretaker
   c) Discuss the caretaker as the stress factor (See also II.7).
10. Students may:
   - Write a brief paper on the psychodynamic dimension of child maltreatment in relation to The Criteria for Emotional Maturity (III.4).
   - Review case histories from Unit II in relation to the psychodynamic dimension of child maltreatment.
   - Invite a resource speaker (e.g., child psychiatrist) to discuss the effects of abuse and neglect in the child.
   - Invite a resource speaker (e.g., social worker) to discuss behavioral problems in the child resulting from physical abuse/neglect versus emotional abuse/neglect. See "Defining Emotional Neglect" (V.8).
   - View and discuss Transparency 17c in relation to the psychodynamic dimension of child maltreatment.
11. Conclude with assessment measures for Performance Objectives 9 through 12.

UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective

The student will develop understanding of the psychodynamic dimension of child maltreatment.

Performance Objectives for Generalization D

14. EXPLAIN the relationship of nurturing experiences in infancy or childhood to the ability to nurture in later life.
15. EXPLAIN the relationship of conditioning toward violence in infancy or childhood to violent behavior in later life.
16. RECOMMEND ways to break the recurring cycle of child maltreatment within society.
17. RECOMMEND ways to break the recurring cycle of child maltreatment within the family and the individual.

Generalization D

THE PSYCHODYNAMIC DIMENSION OF CHILD MALTREATMENT MAY BE MEASURED IN THE RECURRING PATTERN OR CYCLE OF ABUSE AND NEGLECT WITHIN THE SAME FAMILY FROM ONE GENERATION TO THE NEXT.

Sample Content

1. The potentially abusive or neglectful caretaker is often one who was abused or neglected in infancy or childhood:
   a) Deprived of a mothering or nurturing experience
   b) Conditioned toward violence in human behavior
2. The abused or neglected infant or child will frequently in adult life:
   a) Experience difficulty in the adult nurturing role
   b) Adopt violence as a way of life

Suggested Classroom Activities and Procedures for Performance Objectives 14 through 16

1. Prepare students for an understanding of Generalization IV D through a complete review of Unit III, focussing upon III C Sample Content 1 and 2.
2. Review briefly IV A and Definition of Terms (IV.1).
3. Introduce Generalization IV D, and write on board for students.
4. Show Transparency 7, 8, and 9 for examples of the recurring pattern or cycle of abuse and neglect within a given family.
5. Write IV D Sample Content 1 and 2 on board for students.
6. Review II C Sample Content 1 and 2.
7. Show Transparency 10 and have students discuss characteristics of child maltreatment in terms of child-rearing practices as custom or tradition:
    a) How child-rearing practices may differ from family to family
    b) How child-rearing practices originate
    c) The role of the passive partner in child-rearing practices (III B)
    d) The role of the sibling on-looker(s) in relation to child-rearing practices as custom or tradition (III B)
8. Have students read and discuss III.1b and III.8 in terms of child-rearing practices as custom or tradition.
9. Write IV D Sample Content 1 and 2 on board for students.
10. Review the definition for the child maltreatment syndrome (I.1) and III D, the potentially vulnerable child.

11. Point out the recurring pattern or cycle in IV D Sample Content 1 and 2.

12. Have students read and discuss:

    a) "The Abused Parent of the Abused Child" by Wasserman (VI.20)

    b) "Violence in Our Society" by Steele (IV.10)

13. Review and discuss I A Sample Content 1 and 2.

14. Have students read and discuss "Our Forebears Made Childhood a Nightmare" (I.2) in relation to the recurring cycle of violence in society, the family, and the individual.

15. Have students suggest and list on board ways to break the recurring cycle of violence in society, the family, and the individual. (For in-depth study, see Unit VI Child Maltreatment: Help and Hope.)

16. Students may:

    - Write a brief review of IV.6; IV.9; or IV.10.
    - Write a brief paragraph on violence in society, the family, or the individual (which could result in a physically or psychologically damaged child).
    - Research and bring to class current newspaper examples of violence in society, the family, or the individual (which could result in a physically or psychologically damaged child).
    - Invite a speaker from the Mental Health Society to discuss the prevention of mental illness through awareness and understanding of child maltreatment.
    - Roundtable discuss selected articles from "Violence Against Children" _Journal of Clinical Child Psychology_, Fall 1973.

- Research and write a brief paper on the lives of Charles Manson, Sirhan Sirhan, Arthur Bremer, or Marilyn Monroe in relation to the recurring cycle of violence in human behavior.
- Invite a resource speaker to discuss the importance of the nurturing experience in infancy and early childhood in relation to emotional maturity in adulthood.
- Roundtable discuss the use of violence as a form of entertainment in relation to the recurring cycle of violence in human behavior.

17. Conclude with assessment measures for Performance Objectives 14 through 16.

EVALUATION

for

IV. The Psychodynamics of Child Maltreatment

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1, 2 AND 3 --
UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective: The student will be able to explain the psychodynamic dimension of child maltreatment.

Generalization A Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
1. STATE the meaning of the term psychodynamics.	Define the term psychodynamics in relation to child maltreatment.	IV A Sample Content 1 IV.1 I B Sample Content 1 - 4 I C Sample Content 3 III A Sample Content 1 - 3 III.3
2. STATE the meaning of the term interaction.	Define the term interaction in relation to child maltreat treatment.	IV A Sample Content 1 and 2 IV.1 I B Sample Content 1 - 4 I C Sample Content 3 III A III.3
3. EXPLAIN psychodynamic interaction in relation to stress factors: a) within society b) within the family c) within the individual	Define the term psychodynamic interaction in relation to stress, using examples from: a) society b) the family c) the individual	IV A Sample Content 4 IV.1 I B Sample Content 1 - 4 I C Sample Content 3 II.9 III A III.3 III E III.5

Key Word[1] (See Appendix A.)

STATE - to make a declarative word phrase setting forth something

EXPLAIN - to describe the relationship between things and/or /to/ present the reasons for an occurrence or relationship

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[1] Thomas Evaul, Behavioral Objectives, Their Rationale and Development (Merchantville, New Jersey: Curriculum and Evaluation Consultants) 1972.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 4, 5, AND 6 -- UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective: The student will be able to explain the psychodynamic dimension of child maltreatment.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
4. STATE the meaning of the term conscious (re)actions in relation to the caretaker.	Define and give _____ examples of conscious (re)-actions of the caretaker in an episode of child maltreatment.	IV B Sample Content 1, 2, and 3 IV A Sample Content 1 - 3 IV.1 II.4 II.5 II.6 III E III.6 III.7 Film War of the Eggs
5. STATE the meaning of the term unconscious (re)actions in relation to the caretaker.	Define and give _____ examples of unconscious (re)actions of the caretaker in an episode of child maltreatment.	IV B Sample Content 1, 2, and 3 IV A Sample Content 1 - 3 IV.1 II.4 II.5 II.6 III E III.6 III.7 Film War of the Eggs
6. DESCRIBE typical (re)actions of the caretaker to the child.	Describe _____ typical (re)-actions of the caretaker to the child which illustrate psychodynamic interaction.	IV B Sample Content 4 IV A Sample Content 1 - 4 IV.1 II.4 II.5 II.6 II.9 III D III E III.5 III.6 III.7 Film War of the Eggs Transparency 19

Key Word[2] (See Appendix A.)

STATE - to make a declarative word phrase setting forth something

DESCRIBE - to state a verbal picture or /to/list the characteristics of a person, place, thing, or event

[2] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 7 AND 8 --
UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective: The student will be able to explain the psychodynamic dimension of child maltreatment.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 7. DISCRIMINATE conscious and unconscious (re)actions of the caretaker to the child.	Identify the following as a = conscious (re)action b = unconscious (re)action 1. 2. 3. 4. 5. 6. 7. (See itemized resources)	The student will give correct information by utilizing the resources listed below: IV B Sample Content 1 through 4 IV A Sample Content 1 - 3 IV.1 II.4 II.5 II.6 II.9 III D III E III.5 III.6 III.7 Film War of the Eggs Transparency 19
8. EXPLAIN the relationship of stress to the conscious and unconscious (re)actions of the caretaker to the child.	Explain and give ________ examples of the caretaker's (re)actions to the child which illustrate stress as a psychodynamic factor in an episode of child maltreatment.	IV B Sample Content 1 through 4 IV A Sample Content 1 - 3 IV.1 II.4 II.5 II.6 II.9 III D III E III.5 III.6 III.7 Film War of the Eggs Transparency 19

Key Word[3] (See Appendix A.)

DISCRIMINATE - to be able to differentiate one type from another -- similar to "classify"

EXPLAIN - to describe the relationship between things and/or /_to_/ present the reasons for an occurrence or relationship

[3] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 9, 10, AND 11 -- UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective: The student will be able to explain the psychodynamic dimension of child maltreatment.

Generalization C Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 9. STATE the meaning of the term conscious (re)actions in relation to the child.	Define and give ________ examples of conscious (re)actions of the child maltreatment.	The student will give correct information by utilizing the resources listed below: IV C Sample Content 1 - 3 IV A Sample Content 1 - 4 IV.1 II.7 II.8 II.9 III A Sample Content 1 - 3 III C III D III E III.3 Transparency 17 c Transparency 20 a, b, c
10. STATE the meaning of the term unconscious (re)actions in relation to the child.	Define and give ________ examples of unconscious (re)actions of the child in an episode of child maltreatment.	IV C Sample Content 1 - 3 See above.
11. DESCRIBE typical reactions of the child to the caretaker.	Describe ________ typical (re)actions of the child to the caretaker; i.e., to maltreatment which illustrate psychodynamic interaction.	IV C Sample Content 1 - 3 See above.

Key Word[4] (See Appendix A.)

STATE - to make a declarative word phrase setting forth something

DESCRIBE - to state a verbal picture or /to/ list the characteristics of a person, place, thing, or event

[4] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 12 AND 13 --
UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective: The student will be able to explain the psychodynamic dimension of child maltreatment.

Generalization C Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 12. DISCRIMINATE conscious and unconscious reactions of the child to the caretaker.	Identify the following as a) conscious reaction or b) unconscious reaction of the child to the caretaker.	The student will give correct information by utilizing the resources listed below: IV C Sample Content 1 - 4 IV A Sample Content 1 - 4 IV.1 II.7 II.8 II.9 III A Sample Content 1 - 3 III C III D III E III.3 Transparency 17 c Transparency 20 a, b, c
13. EXPLAIN the relationship of stress to the conscious and unconscious reactions of the child to the caretaker (i.e., to maltreatment).	Explain and give ________ examples of the child's (re)actions to the caretaker; i.e., to maltreatment which illustrate stress as a psychodynamic factor in an episode of child maltreatment.	IV C Sample Content 1 - 4 See above.

Key Word[5] (See Appendix A.)

DISCRIMINATE - to be able to differentiate one type from another -- similar to "classify"

EXPLAIN - to describe the relationship between things and/or /to/ present the reasons for an occurrence or relationship

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[5] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 14 AND 15 -- UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective: The student will be able to explain the psychodynamic dimension of child maltreatment.

Generalization D Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 14. EXPLAIN the relationship of nurturing experiences in infancy and childhood to the ability to nurture in later life.	Write a paragraph or paper in which you explain the relationship of nurturing in infancy and childhood to ability to nurture in later life (adolescence or adulthood).	The student will give correct information by utilizing the resources listed below: IV D Sample Content 1 and 2 IV A IV.1 IV.6 IV.9 IV.10 I A Sample Content 1 & 2 I.1 I.2 II C Sample Content 1 & 2 III A III B III C III.1b III.8 VI.20 Transparency 7, 8, 9, 10
15. EXPLAIN the relationship of conditioning toward violence in infancy or childhood to violent behavior in later life.	Write a paragraph or paper in which you explain the relationship of infant or childhood conditioning toward violence to violent behavior in later life (adolescence or adulthood). Name ______ ways in which infant or childhood conditioning toward violence is expressed through violence in later life (adolescence or adulthood).	IV D Sample Content 1 and 2 See above.

Key Word[6] (See Appendix A.)

EXPLAIN - to describe the relationship between things and/or /to/present the reasons for an occurrence or relationship

---

[6] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 14 AND 15 -- UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective: The student will be able to explain the psychodynamic dimension of child maltreatment.

Generalization D Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 16. RECOMMEND ways to break the recurring cycle of child maltreatment within soc society.	Write a paragraph or paper in which you recommend ways to break the recurring cycle of child maltreatment within society. Name ______ ways to break the recurring cycle of child maltreatment within society.	The student will give correct information by utilizing the resources listed below: IV D Sample Content 1 and 2 IV A IV.1 IV.6 IV.9 IV.10 I A Sample Content 1 & 2 I.1 I.2 II C Sample Content 1 & 2 III A III B III C III.1b III.8 VI.20 Transparency 7, 8 9, 10
17. RECOMMEND ways to break the recurring cycle of child maltreatment within the family and the individual.	Write a paragraph or paper in which you recommend ways to break the recurring cycle of child maltreatment within the family. Write a paragraph or paper in which you recommend ways to break the recurring cycle of child maltreatment within the individual. Name _____ ways to break the recurring cycle of child maltreatment within the family/the individual.	IV D Sample Content 1 and 2 See above.

Key Word[7] (See Appendix A.)
RECOMMEND - to present something as worthy of acceptance

[7] Evaul.

CLASS RECORD FORM

S = SATISFACTORY

U = UNSATISFACTORY

UNIT IV: THE PSYCHODYNAMICS OF CHILD MALTREATMENT

CLASS ______________________________ PERIOD _______________

INSTRUCTIONAL OBJECTIVE: The student will be able to explain the psychodynamic dimension of child maltreatment.

	PERFORMANCE OBJECTIVE																	AVERAGE %	
NAME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	S	U
AVERAGE % S																			
U																			

CLASS AVERAGE

GRADE KEY

S----SATISFACTORY for PERFORMANCE OBJECTIVES

U----UNSATISFACTORY for PERFORMANCE OBJECTIVES

60% SATISFACTORY = CREDIT for COURSE

STUDENT ______________________

FINAL GRADE

TOTAL % SATISFACTORY for COURSE ____

TOTAL % UNSATISFACTORY for COURSE ____

INDIVIDUAL STUDENT RECORD

	PERFORMANCE OBJECTIVES																	AVERAGE % Instructional Objectives S	U
UNIT I Instructional Objective	1	2	3	4	5	6	7	8											
UNIT II Instructional Objective	1	2	3	4	5	6	7	8	9	10									
UNIT III Instructional Objective	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
UNIT IV Instructional Objective	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17		
UNIT V Instructional Objective One	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
UNIT V Instructional Objective Two	1	2	3	4	5														
UNIT VI Instructional Objective One	1	2	3	4															
UNIT VI Instructional Objective Two	1	2																	

CLASSROOM INSTRUCTIONAL MATERIALS

for

IV. The Psychodynamics of Child Maltreatment

SELECTED RESOURCES

1. Definition of Terms (IV.1)
2. Psychodynamic Interaction Illustrated, Doonesbury Cartoon Series (IV.2)
3. Typical Conscious and Unconscious (Re)Actions of the Caretaker to the Child (IV.3)
4. Typical Conscious and Unconscious (Re)Actions of the Child to the Caretaker, i.e., to Maltreatment (IV.4)
5. The Violence Cycle Illustrated, "World of Abnormal Rearing" (IV.5)
6. "Early Child Abuse and Adolescence, A Literature Review" (IV.6)
7. "Home Called More Violent Than Street" (IV.7)
8. Ann Landers' Column (IV.8)
9. "The Child-Abusing Parent: A Psychological Review" (IV.9)
10. "Violence in Our Society" (IV.10)
11. Selected Instructional Material from Units I, II, and III
12. Classroom learning center for child maltreatment

AUDIOVISUAL MATERIALS

Overhead Transparencies

18. Psychodynamic Interaction Illustrated, Doonesbury Cartoon Series 1 through 6
19. Typical Conscious and Unconscious (Re)Actions of the Caretaker to the Child (a, b, c)
20. Typical Conscious and Unconscious (Re)Actions of the Child to the Caretaker; i.e., to Maltreatment (a, b, c)
21. The Violence Cycle Illustrated, "World of Abnormal Rearing"

Films

War of the Eggs. A heart-rending incisive story of a young couple who quarrel and as a result, their young son begins to cry hysterically. The enraged young wife roughly pushes him down the stairs, badly injuring him. At the hospital a psychiatrist gently tries to help them. Painfully, husband and wife open to each other, accept responsibility for what they have done, and turn for help. Written by Michael Crichton, author of Andromeda Strain.

Paulist Productions 1974 16mm color 26½ min. MCPS Film Library

Rockabye Baby. A film which illustrates the effects of parental deprivation upon young animals and children. The importance of physical touching and body movement for normal social and emotional development are effectively dramatized through this film. It presents some of the techniques that psychologists use to measure mothering practices during the importnat infant years.

Time-Life Films, Inc. 1971 16mm color 20 min. MCPS Film Library #6095

THE PSYCHODYNAMICS OF CHILD MALTREATMENT

*Definition of Terms (IV.1)

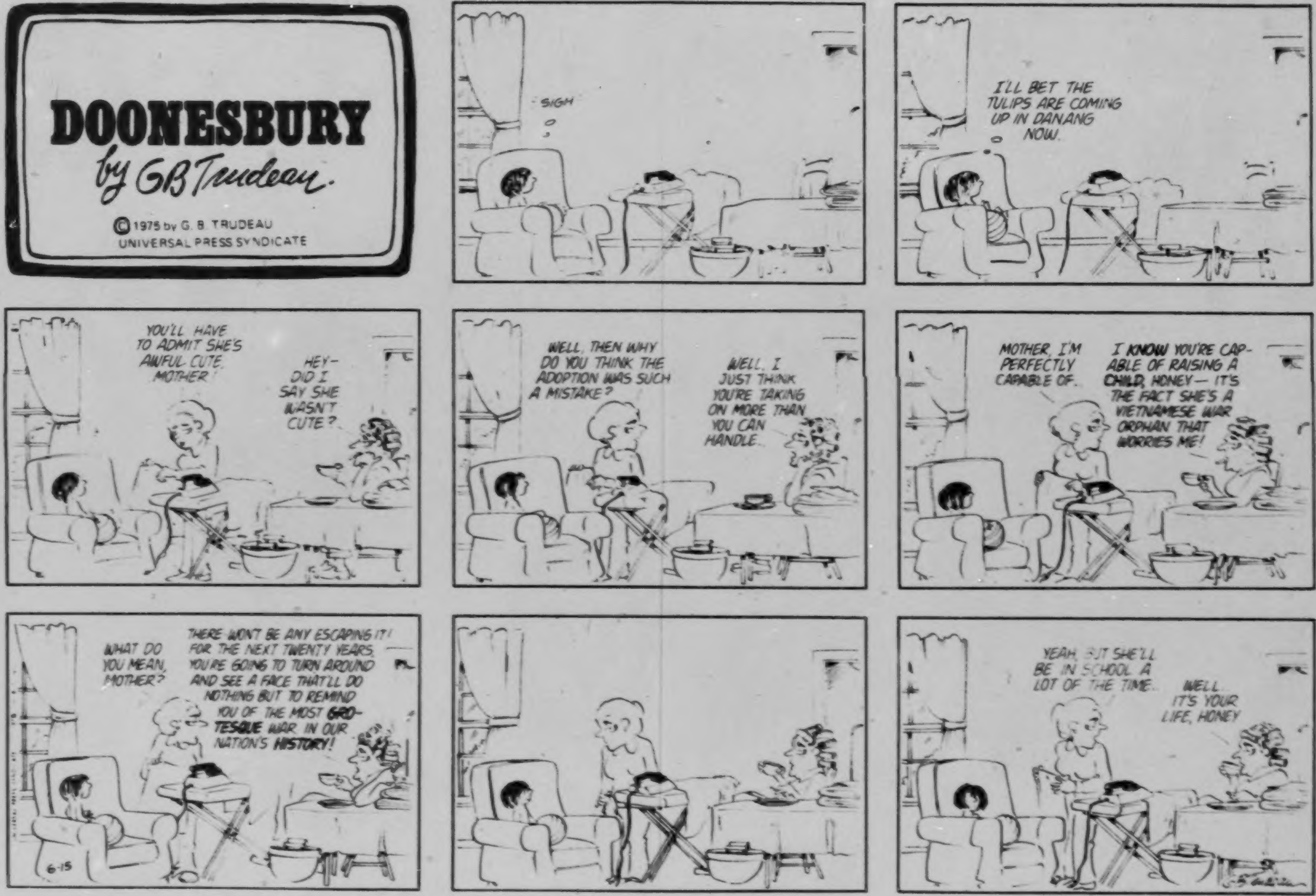
1.	Physical	adj.	- 3a: of or relating to the body b: concerned or preoccupied with the body and its needs
2.	Psychological	adj.	- 2: directed toward the will or toward the mind
**3.	Dynamics	n.	- 2: the driving physical, moral, or intellectual forces of any area or the laws relating to them
4.	Psychodynamics Psychodynamic	n. adj.	- the psychology of mental or emotional forces or processes developing esp. in early childhood and their effects of behavior and mental states 2: explanation or interpretation (as of behavior or mental states) in terms of mental or emotional forces or processes 3: motivational forces acting esp. at the unconscious level
5.	Personality	n.	- 3a) the complex of characteristics that distinguishes an individual b(1): the totality of an individual's behavioral and emotional tendencies (2): the organization of the individual's distinguishing character traits, attitudes, or habits
6.	Interaction	n.	- a mutual or reciprocal action or influence
7.	Psychodynamic interaction	n.	- a (re)action in response to an influence (past or present), an event (past or present), or a person (past or present)
8.	Conscious reaction	n.	- reactions which are marked by thought, will, or design
9.	Unconscious reaction	n.	- reactions which are not known or perceived; unaware

* Webster's New Collegiate Dictionary, 1974

** Webster's Seventh Collegiate Dictionary, 1966

(Transparency 18)

IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT (IV.2)


DOONESBURY
by GB Trudeau.
© 1975 by G. B. TRUDEAU
UNIVERSAL PRESS SYNDICATE
SIGH
I'LL BET THE TULIPS ARE COMING UP IN DANANG NOW.
YOU'LL HAVE TO ADMIT SHE'S AWFUL CUTE, MOTHER!
HEY- DID I SAY SHE WASN'T CUTE?
WELL, THEN WHY DO YOU THINK THE ADOPTION WAS SUCH A MISTAKE?
WELL, I JUST THINK YOU'RE TAKING ON MORE THAN YOU CAN HANDLE..
MOTHER, I'M PERFECTLY CAPABLE OF..
I KNOW YOU'RE CAPABLE OF RAISING A CHILD, HONEY— IT'S THE FACT SHE'S A VIETNAMESE WAR ORPHAN THAT WORRIES ME!
WHAT DO YOU MEAN, MOTHER?
THERE WON'T BE ANY ESCAPING IT! FOR THE NEXT TWENTY YEARS, YOU'RE GOING TO TURN AROUND AND SEE A FACE THAT'LL DO NOTHING BUT TO REMIND YOU OF THE MOST GROTESQUE WAR IN OUR NATION'S HISTORY!
6-15
YEAH, BUT SHE'LL BE IN SCHOOL A LOT OF THE TIME..
WELL.. IT'S YOUR LIFE, HONEY

(Transparency 19 a, b, c)

THE PSYCHODYNAMICS OF CHILD MALTREATMENT

TYPICAL CONSCIOUS AND UNCONSCIOUS (RE)ACTIONS OF THE CARETAKER TO THE CHILD

(IV.3)

- Expects (demands) the child to perform above his/her physical, emotional, or intellectual capacity
- Uses the child as an object of aggression in order to discharge hostility directed toward another; i.e., as a "pawn"
- Depends upon the child to fulfill the emotional or physical needs of the caretaker, unrelated to or disregarding the child's own needs
- Attributes to the child inappropriate or adult feelings and capabilities
- Ascribes to the child the guilt feelings of the caretaker; i.e., uses the child as a "scapegoat"
- Views the child as a competitor or a burden
- Perceives the child as unloveable without apparent reasons
- Identifies the child with self or some other hated person
- Associates the child with unpleasant experiences
- See Typical Acts of Physical and Psychological Abuse (II.4). Review in terms of typical conscious or unconscious reactions on the part of the caretaker.
- See Typical Acts of Psychological Abuse Without Physical Abuse (II.5). Review in terms of typical conscious and unconscious reactions on the part of the caretaker.
- See Typical Acts of Physical and Psychological Neglect (II.6). Review in terms of typical conscious or unconscious reactions on the part of the caretaker.

(Transparency 20 a, b, c)

THE PSYCHODYNAMICS OF CHILD MALTREATMENT

*TYPICAL CONSCIOUS AND UNCONSCIOUS (RE)ACTIONS OF THE CHILD TO THE CARETAKER; i.e., TO MALTREATMENT (IV.4)

Disturbed eating habits; i.e., irregular, too much, too little

Nightmares

Bedwetting, soiling

Extreme passivity

Extreme aggressiveness

Antisocial behavior; e.g., stealing, fire-setting, addiction, violence

Apathy and withdrawal

Infantile behavior; e.g., infantile speech, thumbsucking

Stuttering

Loss of speech

Growth retardation

Mental retardation

Academic failure

Temper tantrums

Social retardation

Delayed motor development

Hypersensitivity (auditory and/or visual)

Sadomasochistic behavior

Failure-to-thrive

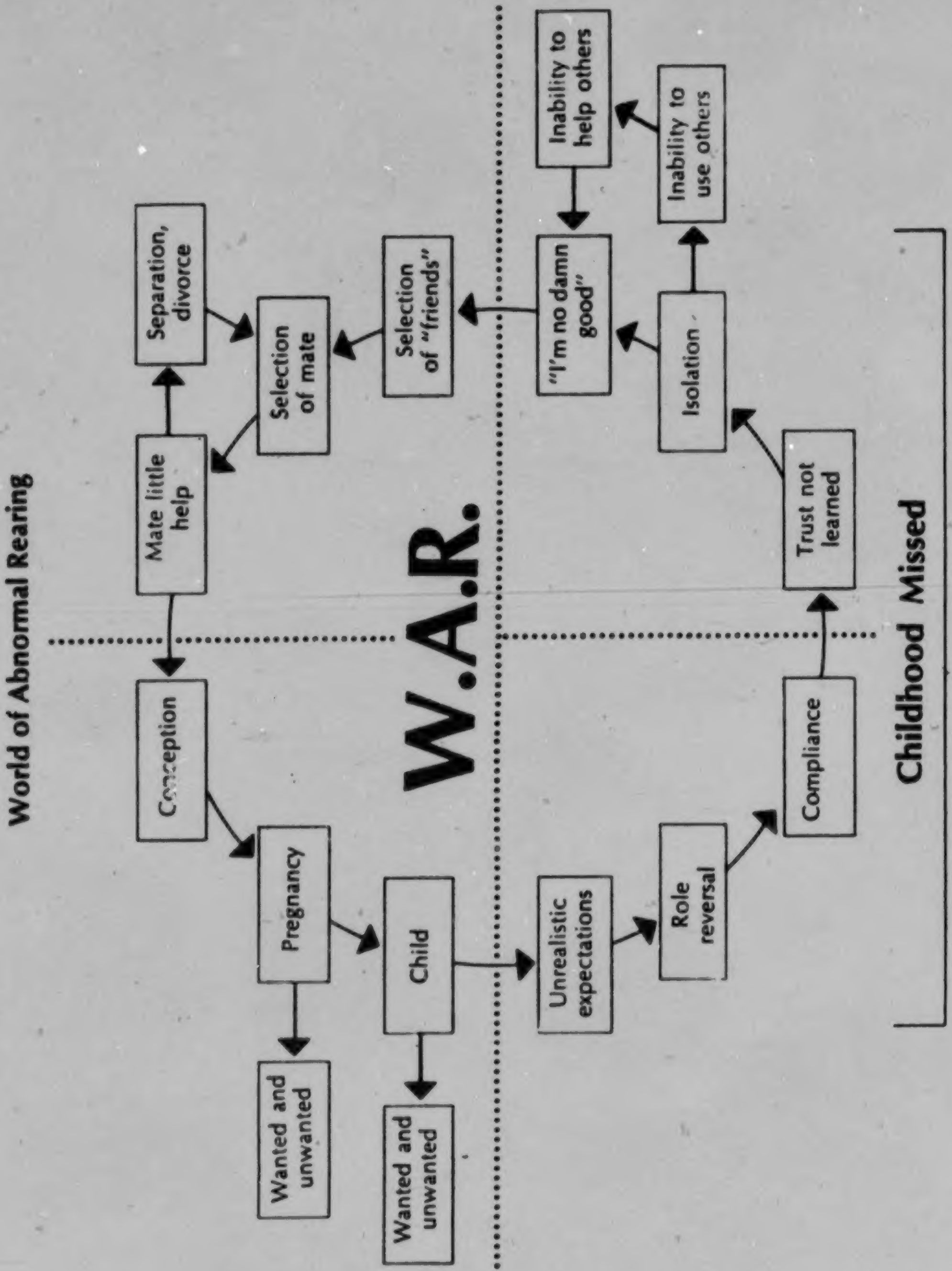
Abnormal fears

NOTE: Similar manifestations may arise from other causes.

*See Typical Manifestation of Psychological Abuse and Neglect in the Child (II.9).

(Transparency 21)

IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT (IV.5)


World of Abnormal Rearing
W.A.R.
Childhood Missed
Conception
Pregnancy
Wanted and unwanted
Child
Wanted and unwanted
Unrealistic expectations
Role reversal
Compliance
Trust not learned
Isolation
Inability to use others
Inability to help others
"I'm no damn good"
Selection of "friends"
Selection of mate
Separation, divorce
Mate little help

IN THIS ISSUE

The Center Quarterly Focus
Spring, 1975.
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The Center Quarterly Focus is on a review of the literature concerning early child abuse and its relation to adolescence.

Colleen Baumtrog[1] came to the Center for Youth Development and Research to explore the effects of early child abuse on adolescence as a means of illuminating her work with a thirteen year old girl in a residential treatment center for disturbed children. Her questioning led to an examination of the literature on early child abuse — definition, history, incidence, demography, etiology — and its relation to adolescence. She undertook this literature review as an independent study project at the Center for Youth Development and Research. It has been edited for publication and reflects, in its publication, the Center's commitment to including young persons in every aspect of its work.

This review underscores the need to pursue at least two additional issues: *The first* is "adolescent abuse" per se, though it seems likely that most young people suffering abuse as adolescents also experienced such treatment as children.

> "Abuse of adolescents and youth is being reported more frequently in some communities. They may provoke adults into assaulting them ('conflict of values') or the abuse may represent an extension of the phenomenon of the abuse of infants and small children."[2]

The definition of "child abuse" Ms. Baumtrog uses clearly encompasses persons in adolescence. Yet despite increasing concern and comment about adolescent abuse, it has not generated a critical mass of research and documentation with implications for practice. This is changing.

Dr. Gisela Konopka, Director, Center for Youth Development and Research, and author of a recent study on the adolescent girl[3], notes that:

> "At this time in our history, we are very concerned and have become more aware of the 'battered child' but this is mostly seen in terms of the very young child. Without looking for it, we found 'the battered adolescent'. The girls talk about beatings, rapes, being molested by adults, and about resulting suicide attempts, running away, and a general sense of their being 'all bad'."

She goes on to say:

> "It is a mistake to think that this occurs only in low income groups . . .
> ". . .that this occurs exclusively in urban areas . . .
> ". . .that violence occurs predominantly in minority groups. . ."

And then asks:

> "Who could live normally through such terror? And how often must they hold in all other anguish because of fear? . . .
>
> "It can happen that they become as violent as their parents . . .
>
> ". . . returned violence with violence . . ."

Moreover, she says:

> "We found 'battering' of adolescent girls in their homes *and in the institutions which should serve them.*" (emphasis added)

Along the same line, ten Bensel and Watson[4] note that:

> "Of all service-providing agencies and organizations, schools are in the best position to take the initial steps to protect abused and neglected children and youth. It is school personnel who see children and young people, observe their appearance and behavior, and interact with them daily. It is they who are able to identify the signs of neglect or 'suspected' abuse and initiate the intervention of protective and therapeutic services."

They urge upon school personnel, and offer guidelines for 1) more *understanding* of abuse and neglect coupled with *reporting and treatment*, 2) *development and implementation of school policies and procedures* regarding abuse and neglect.

The *second* related issue needing further attention is that of helping parents with their child rearing practices, and in particular families where abuse in any or all of its forms occurs. Beginning change in this area is expressed most noticeably in an increasing concern for parent education ranging from *education for potential parents* while still in junior high school, to *parents*, regardless of the age of their children: infancy through adulthood.

Miriam Seltzer
Editor

EARLY CHILD ABUSE AND ADOLESCENCE-

A Literature Review by
Colleen Baumtrog

"...the child is psychologically the father of the man and the events of his first years are of paramount importance for his whole subsequent life."

Sigmund Freud, 1940
An Outline of Psychoanalysis

FOCUS OF CONCERN

Increasing concern over child abuse has produced research, legislation, and education of individuals whose jobs bring them into contact with possible victims of child abuse, as well as attempts to understand and help abusive parents. Efforts to reduce child abuse and deal with it when it arises are commendable, but child abuse is more than a medical and legal problem. Its effects linger long after the abuse is reported and stopped and the physical damage is repaired.

The focus of this paper is on a neglected but significant area of concern: *the psychological and emotional effects of abuse in early childhood on the functioning of adolescents.* Adolescence is seen as a unique stage of development characterized by rapid cognitive and physical growth which precipitates specific problems. Often it is not until adolescence that abused children come to the attention of mental health professionals (and frequently juvenile court authorities). Since adolescence is a period crucial to the development of an integrated well adjusted individual, it is particularly important that appropriate treatment be given at this time.

DEFINITION

For the purposes of this paper the definition contained in the Child Abuse Prevention and Treatment Act of 1973 serves as an adequate representation of the phenomena to be investigated:

> "...'child abuse and neglect' means the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under the circumstances which indicate that the child's health or welfare is harmed or threatened...."

This particular definition was chosen because it is broad and is legally recognized. Many studies dealing with child abuse unfortunately have dealt with only a portion of the definition, limiting their samples to victims of sexual abuse, for example, or broken bones, or malnutrition. Repeated physical abuse or battering is only one type of abuse. It produces concern and shock, yet it may not be the most dangerous type because children with obvious clinical signs of abuse receive attention and thus are better off (provided they survive, of course) than those who go undetected.

HISTORY

Child abuse has been practiced since the beginning of recorded time. Reasons for its existence are varied. Among them are religious appeasement, reactions to prophecies of doom, cultural tradition, population control, and mere discipline. Theo Soloman (1973) states that infanticide has been responsible for more children's deaths than any other cause in history except perhaps the bubonic plague. Infanticide was reported as a regular feature of many cultures including Eskimo, Polynesian, Egyptian, African, American Indian, and Australian aborigine. As late as 1837 female infanticide was permitted in China. The rationale for this practice has changed as society changed.

Pediatric radiology contributed greatly to the current surge of interest in child abuse. Caffey (1946) was the first to report his original observations regarding the common association of subdural hematoma and abnormal x-ray changes in the long bones. Then Silverman (1953), who reported similar findings, clearly defined the traumatic nature of the cause of these lesions. The news reached radio, television, and the press — electrifying the public as well as many social agencies. Kempe's work (Kempe et al. 1963) served as an impetus for present day concern. It was he who coined the phrase "the battered child syndrome."

Active involvement of the American Academy of Pediatrics, the Children's Bureau, the American Humane Society, and other medical and social groups throughout the nation attest to the seriousness of the problem of child abuse. Judicial and legal authorities also have recognized the importance of protecting the rights of children. Through the combined efforts of all these groups mandatory reporting laws have been passed in all of the 50 states.

INCIDENCE

The true incidence of child abuse is not known. Reliable data are lacking. Even the most "educated" estimates probably are conservative. Many cases are overlooked or unrecognized, and not reported, much less investigated. The amount of abuse can be likened to an iceberg, its tip analagous to the *reported* cases. Fontana (1973) notes that 956 cases were reported from New York City alone in 1968. Each year since then the number has almost doubled, rising to over 5,200 in 1972. Data from California and Colorado, when extrapolated, yield an estimate of 200,000 to 250,000 children abused annually in the United States. Kempe (1972) estimated the number to be 60,000. In Congressional testimony (1973) it was estimated that 6,000 children die each year as a result of abuse. Reported abuse unquestionably is increasing. Whether this reflects improved reporting rates or an actual increase in incidence, or both, the data are startling. It should also be noted that even less is known about the incidence of emotional and psychological abuse of children. The lack of an accepted operational definition of such abuse is a major obstacle to such documentation.

DEMOGRAPHICS

Although the literature appears to be contradictory, when the type of research and its populations are taken into consideration along with other facts concerning class differences in the United States today, the demographic picture of child abuse emerges. Abuse occurs in lower, middle and upper class families; it is not solely a function of educationally, occupationally, or socially disadvantaged parents. Regional and sex distribution of abuse appears to have minimal correlation to child abuse.

Abused children who are brought to the attention of health professionals tend to be very young (Schloesser, 1964). Kroeger (1965) notes that data obtained from sources other than hospital studies indicate age distributions less skewed towards the very young. A possible explanation is that young children may sustain more severe injuries and therefore are more likely to be seen in hospitals. Also they are less able to run away or defend themselves in other ways.

The majority of studies, regardless of their sample populations (Steele et al, 1968; Elmer, 1963; ten Bensel, 1975) support what Schloesser, (1964) found in her study, namely, that abused children do not differ in racial background from the general population.

In summary, indications are that the causes of child abuse are more subtle than can be detected from investigating demographics such as religion, sex, age, race, or socioeconomics. Even when the investigations conclude that one of these factors is differentially involved, such as age, the findings only lead to more questions.

ETIOLOGY

Parent abusers are not a homogeneous group. On the surface they represent a random cross section of the general population. They emerge from all socioeconomic strata; they live in large metropolitan areas as well as small towns; their housing varies from substandard to high class suburban; their educational achievement ranges from partial grade school to post-graduate degrees; their religious affiliations include Catholic, Jewish and Protestant. The psychopathology they exhibit is representative of the wide spread of emotional disorders seen in any clinic population. Steele et al (1968) in their psychiatric study of parents who abuse their children found that with few exceptions the parents had emotional problems of sufficient severity to be accepted for treatment had they sought psychiatric help.

From the literature reviewed, it appears that three main characteristics of parent abusers are consistently related to the occurrence of child abuse: (1) interpersonal relationship of problems resulting in part from personality disturbances; (2) a history of abuse when they were children; (3) inappropriate expectations of the abused child.

Problems of interpersonal relationship

Kempe (1972) noted that the abusing parent is often trapped in a "hopeless pattern of living." In general, marriage relationships are poor and close family or social relationships are lacking. Thus the needs of the abusive parent are not met by spouse, family or friends. Zalba (1971) concludes that in his study all the parent abusers are characterized as highly impulsive, socially isolated, and in serious difficulties with their marriage, money, etc. The Massachusetts SPCC reported that in 50 percent of the 115 families they studied there was premarital conception. Other studies also point out the typicality of youthful marriages, unwanted pregnancies, illegitimacies, and forced marriages (Merrill, 1962; Elmer, 1967; Zalba, 1971).

Merrill (1962) notes three distinct clusters of personality characteristics in the parents he studied. The first group shows traits of hostility and aggressiveness with the appearance of being continually angry. This anger was described as stemming from conflicts within the mothers themselves. Flynn (1970) also cites parental anger in the form of defective defense structures of the ego, which causes the parent to project anger onto their children while denying and repressing it in themselves. The second group Merrill describes is identified by personality characteristics of rigidity, compulsiveness, and lack of warmth. Many mothers in this group exhibited marked rejection attitudes toward their children. The third group of parents showed strong feelings of passivity and dependency. These parents competed with their children for the love an[illegible]ttention of their spouses.

History [illegible]buse as children

Perhaps more important than the foregoing characteristics, one or more of which appear in many American families, is the finding that abusive parents themselves have been abused and neglected as children (Zalba, 1971). The literature reviewed indicates that parents raise their children in the same style in which they were raised. Steele et al (1968) found, for example, that many parent abusers had experienced severe abuse in the form of beatings. Silver et al (1969) in a study covering three generations of families of abused children conclude that violence breeds violence, and that an individual who experiences violence as a child has the potential of becoming a violent member of society in the future.

Blumberg (1974) notes that abusing parents were themselves abused, neglected, and deprived of love and mothering when they were children. He suggests that as a result of this early rejection they never developed the ability to love. Studies involving several generations (Oliver and Taylor, 1971; Oliver and Dewhurst, 1969; Dewhurst et al, 1970) describe families with numerous members suffering from mental disturbances, including disturbances of personality and low intelligence. These studies emphasize that preventing the infliction of prolonged mental and physical suffering on children should be the core of preventive psychiatry.

Though evidence that today's abusive parents have a disturbed history seems clear enough, it is noted by several investigators (Spinetta et al, 1972; Kempe, 1971; Steele, 1968; Morse et al, 1970) that this factor by itself is not sufficient to result in child abuse.

Inappropriate expectations

A third quality abusive parents have in common is that they project inappropriate expectations onto their children. These demands and expectations are unrealistic because they are often beyond the ability of the children to comprehend. Kaufman (1962) describes this practice as parental distortion and misperception. He states "the child is not perceived as a child, but some symbolic or delusional figure" and may be perceived as the psychotic portion of the parents which they wish to control or destroy. Kaufman believes that parents project much of their own difficulty onto the child and feel that he or she is the cause of their troubles. As a result they attempt to relieve their anxiety by attacking the child instead of facing their own problems. Kaufman conceives of this as a type of "schizophrenic process" because of the strong use of denial and projection. Pollack (1968) disagrees with the label, but essentially agrees with the process.

Abuse-provoking characteristics of child

Looked to recently in exploring the etiology of abuse are two factors that are not necessarily related to the parents but rather are conditions that the potential abusers find themselves in. One has been called the "abuse provoking" characteristics of the child. The product of a difficult pregnancy who starts life being viewed as a troublemaker (Kempe, 1972) is one example. Morse et al (1970) notes that many abused children are mentally retarded and hyperactive. Based on their studies, Milow and Lourie (1964) and Terr (1968) suggest the abused child may inadvertently have a significant role in his own battering by reason of his physical or mental condition. The Denver Department of Welfare study shows that almost 70 percent of the abused children exhibited some physical or developmental deprivation *prior* to the reporting of injury. Elmer (1960) in her hospital survey judged 71 percent of her subjects to be mentally retarded and 30 percent emotionally disturbed.

The abused child may also have qualities which have negative associational effects for the abusing parent. He may remind the parent by looks, time of birth, or mannerisms of an event or a person the parent would rather not remember. Research involving "high risk" groups of children reflecting a variety of intellectual, physical and emotional problems needs to be done.

Precipitating crisis

A second factor associated with child abuse but not directly related to the qualities of the parent is some type of precipitating crisis. Kempe (1972) says, "in the early stages of dealing with parents, it is always safe for the worker to assume that some sort of crisis has occurred in the family." One explanation of why some studies (Gil, 1970) found a significantly greater number of abuse cases in low socioeconomic status families would be that the poorer the family the more likelihood of economic stress and thus the more crises — at least in financial terms. Gelles (1973) in an argument against the psychopathological model that is frequently used to explain child abuse suggests that a more dimensional approach to child abuse is possible by focusing on the sociological and contextual variables associated with abuse.

In summary, there are many factors which influence child abuse. Included are qualities of the abusive parent, qualities of the abused child, and sociological and contextual situations that result in a precipitating stressful event which sparks the abuse. Spinetta et al (1972) emphasize that while socioeconomic circumstances might place added stresses on basic personality weaknesses, these stresses are not themselves sufficient or necessary causes of abuse. Helfer (1973) points out that recognition of the *potential* abuse situation requires recognition of the *total* situation long before abuse occurs. He warns that although a crisis situation should receive attention, solving a crisis alone is not enough and will "only put the fire out for a little while."

EFFECTS OF EARLY CHILD ABUSE ON ADOLESCENCE

Adolescence at best is fraught with problems and potential dangers. Prior abuse increases the hazards and the severity of the problems. For example, an adolescent whose first four years were filled with traumatic batterings, perhaps disguised as severe discipline, certainly has had a pathological relationship with his parents. This developmental stage, described by Erickson (1968) as trust versus mistrust, probably remains unresolved. Taipale et al (1972) conclude that a seven-year-old who was grossly mishandled at age two is less adversely affected by his slight brain damage than by the basic weakness of his sense of trust, thus impairing his ability to relate to new foster parents.

Many adolescents today are drawn to the attention of juvenile authorities and are placed in detention centers, residential treatment centers, or foster homes as a direct result of their inappropriate aggression. These adolescents are considered to be delinquent antisocial types, and the current prognosis for their developing into socially acceptable individuals looks dim. It is suggested that investigation of the background of these adolescents would show that a majority had (and probably still have) severe pathological relationships with their parents which took the form of child abuse, or at best would be called rigid, punitive discipline. Fenby (1972) in his article on the workings of the National Society for the Prevention of Cruelty to Children, discusses the cycle of delinquency and child abuse. Stele and Hopkins (unpublished) in a study done at a detention center in Brighton, Colorado (unpublished), interviewed 100 adolescents and at least one parent of each. Among other things, they found 84 percent of the residents had been abused.

Prolonged abuse and maltreatment, plus a lack of adequate parental models, breed frustration. At adolescence, when bodily and cognitive changes are happening fast, this built-up frustration often is released through aggression.

Aggression — the expression in adolescence of early child abuse

Sigmund Freud viewed aggression as an instinctual drive and as one of the most fundamental motivators of behavior (along with the sex drive). Watson, on the other hand, limited his innate motivators to hunger, thirst, sex, and a few specific fears (loud sounds, for example). He left the explanation of aggression exclusively to learning. Aggression, for the purposes of this paper, is viewed as having characteristics of both. It has its basis in an instinctual drive system that has enabled men to survive, yet the expression of aggression and the qualitative and quantitative forms it takes in an individual's life are left largely to experience.

An experience shown to lead to aggression is frustration. Dollard et al (1939) who were the first to study aggression systematically were influenced by Freud's concepts of aggressive impulses, but they rejected Freud's instinct theory in favor of their own hypothesis that aggression is always a response to some form of frustration. Several studies have demonstrated that frustration does lead to aggression. Block and Martin (1955) and Mallick and McCandles (1966) demonstrated that children become more aggressive following experimentally induced frustration. Sears et al (1953) found significant relations between measures of early frustration and later aggressive behavior. Rolston (1971) in his dissertation thesis demonstrated that prior physical abuse (surely a frustrating experience) is correlated with overt and fantasy aggressive behavior of children who had been placed in foster homes.

Bandura and Walters (1959) compared attitudes and family background of antisocial aggressive boys with those of a matched control group of non-aggressive boys. They uncovered numerous group differences. Analyzing these differences in an attempt to explain the failure of the aggressive boys to identify with and internalize societal standards for behavior, they concluded that (1) the father's hostility, and (2) the mother's rejection and discouragement of their sons' dependency needs were two major factors contributing to the etiology of their sons' aggressive behavior.

Bandura and Walters (1959) also concluded that the parents of aggressive boys had significantly more often encouraged aggression and had presented aggressive models in their attitudes and in their frequent use of physical punishment. From what could be gathered about the aggressive boys' early life history, aggression had long been a problem, but during adolescence — mainly because of the boys increased size, physical maturity and independence — it became more like a crisis.

Eron, Walder, and Lefkowitz (1971) also found physical punishment, rejection, lack of nurturance, marital discord, and aggressiveness by parents to be positively related to aggression in children. In addition they found that the children who identified strongly with their parents grew less aggressive the more they were punished for aggression, while among boys who did not identify with their fathers, punishment increased aggression. Since most did not identify strongly with their parents, the general effect of severe punishment was to increase aggression. Kempe (1971) presents an explication of the diagnosis and treatment of abused children based on the concept that child abuse is caused by a disturbance in mothering. It is that early frustration as a result of abuse, together with an inadequate parent-child relationship, can lead to inappropriate aggression as the child becomes an adolescent.

In summary, although this is by no means an all-inclusive presentation of the literature on aggression, it suggests that as a result of child abuse (which is seen as representing a maladaptive parent-child relationship) antisocial and aggressive behavior appear and are of grave concern to parents and society when these abused children become adolescents and are no longer easily controllable.

Inappropriate aggression is only one of the possible effects of child abuse, though it certainly draws the most attention. Unfortunately, other effects of abuse remain unknown and thus untreated.

It is also unfortunate that adolescents exhibiting aggression related problems are seldom recognized as having been abused and thus the "treatment" (actually more like punishment) administered does not attempt to reconcile the early maladjustment. Instead the adolescent is seen as having a "behavior" problem and methods such as behavior modification are used to change behavior, not to deal with the underlying *cause* for that behavior.

Conclusion

Specific problems manifested during adolescence are a result of the physical and cognitive changes of the period, together with the effects of a disturbed early development characterized by a pathological parent-child relationship and physical or emotional abuse or both. It is unfortunate that pity and disbelief prevail in dealing with abused infants and children while fear and misunderstanding characterize the handling of these children when they become adolescents. In both cases society mishandles the situation.

The practice of focusing solely on the medical aspects of abuse and the possible removal of the child from the home is inadequate. Treatment of adolescents should include efforts to deal with the etiology of their maladjustment. These adolescents should be treated as disturbed human beings who need and often want help, not as delinquents or criminals needing incarceration.

A considerable amount of knowledge exists about the when, where, why and how of abuse, but this is not enough. The psychological and emotional effects of child abuse are far more severe than the medical effects, if for no other reason than because we do not know how to deal with them. Therefore it is long overdue that society deals with child abuse realistically; treatment of these children once abuse has occurred should include psychological as well as medical treatment.

Finally, adolescents with histories of abuse, especially when the parent-child relationship is disturbed, should receive help, not punishment and socially derogatory labels.

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[2] ten Bensel, Robert W. and Jane Watson, "The Neglect and Abuse of Children: The Scope of the Problems and the School's Role", *Minnesota Journal for Health, Physical Education and Recreation*, Spring Summer, 1975

[3] Konopka, Gisela, *Young Girls, A Portrait of Adolescence*, to be published by Prentice-Hall, Inc., Fall 1975

[4] op. cit p. 13

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CENTER for Youth Development and Research
QUARTERLY Focus
Spring 1975

The Center Quarterly Focus is published by the Center for Youth Development and Research, University of Minnesota, to communicate significant current thinking and research on issues and problems concerning youth. Youth is defined as the state in the life cycle that begins in adolescence and continues until adulthood — essentially the period between childhood and economic independence. Manuscripts invited. Gisela Konopka, Director; Miriam Seltzer, Editor; Lillian Jensen, Technical Editor; Terry Anderson, Bibliographic Assistant. Offices at 325 Haecker Hall, University of Minnesota, St. Paul, Minnesota. Spring, 1975.

Home Called More Violent Than Street

By Edward Schumacher

Special to The Washington Post

BOSTON, Feb. 24—From a slap in the face to murder, violence is more likely to occur between members of the family than anyone else.

And yet the laws protecting wives and children, the principal victims, are weak and poorly enforced, a panel of criminologists reported to a meeting here this week of the American Association for the Advancement of Science.

No thorough national studies have been done, they said, but according to accumulated scraps of data and a number of limited studies, the problem is worse than crime on the streets.

"If you're going to be killed in America, if you're going to be beaten up in America, it's more likely to happen by someone in your own family," University of Rhode Island Professor Richard J. Gelles said.

Gelles said in a study of 86 families in a small New Hampshire town, 56 per cent of the parents said that they intentionally tried at least once to physically harm their spouse. One beats the other at least monthly in 25 per cent of the families.

A recent study in Delaware by University of Delaware Professor Suzanne K. Steinmetz produced similar figures.

Turning to child abuse, Gelles said the estimate of 1 million children injured each year was conservative.

That same number of abused children was reported to police, according to the American Humane Association in a study last year for the Department of Health, Education and Welfare. The beatings were not confirmed, but, Gelles and other experts estimate, two to three times more child abuse cases went unreported.

In the murder category, about 25 per cent of the killings in the nation's cities involve parents and children, according to studies cited by University of New Hampshire Professor Murray S. Straus.

Gelles estimates that the level of family violence has remained about the same in recent years. He said the sharp rise in police reports is probably due to a growing willingness to report family members.

The growing independence of women has helped take the problem "out of the closet," he said. Now, however, it is unclear if that independence will increase or decrease wife beatings—or husband beating.

Reasons for family violence presented by experts here include emotional intensities and physical proximities of living in a family, age and sex discrepencies, and alcohol usage. It is unclear whether violence is higher in economically poorer homes, they said.

Another primary factor in family violence is the use of physical punishment — "spanking" — to discipline a child. Straus, Gelles and Steinmetz report that 84 to 97 per cent of American families use physical punishment at some point in a child's life.

They cited a number of studies that conclude that physical punishment leaves personality traits of aggression and guilt and attitudes approving the use of violence to affect social reform.

Punishment also associates love with violence, Mary said.

"The child learns that those who love him or her the most are also those who hit and have the right to hit," they reported. "The second unintended consequence is the lesson that when something is really important, it justifies the use of physical force."

A problem in trying to curb family violence is reluctance of the police, the courts, and the governments to pass and enforce laws that intrude on the family. In many states, for instance, wives are not allowed to sue their husbands for rape or assault and battery.

"We're talking about a couple of million wives getting beat up regularly and don't know what to do about it," Gelles said.

America Said to Face 'Female Crime Wave'

BOSTON, Feb. 24 (UPI)—America is facing a "female crime wave" and there may be more behind it than just the women's liberation movement that often is cited as the cause, a New York sociologist said today.

Dr. Florence L. Denmark said the reasons responsible for the sharp rise in female crime rates during the past decade probably go far deeper than the increasing awareness of women's options in society.

"The female offender, whether acting by herself or with others, is not typically the emancipated intellectual striving for civil liberties," Denmark told a final session of the annual meeting of the American Association for the Advancement of Science.

"Her crime is rarely an assertion of equal rights, or an unconscious attempt at achieving her own or other's rights. She may feel dominated by men or even wish to imitate men or obtain male approval for her actions."

In a report written with Dr. Ruth Rutschmann-Jaffe of Barnard College, Denmark said that although arrests of men are still far greater then women, the rate of increase in female arrests between 1960 and 1973 was three times that of males. Arrests for violent crimes increased by 278 per cent for women compared to 88 per cent for men.

"Clearly, women are no longer limiting themselves to so-called traditionally female crimes of shoplifting and prostitution," Denmark said. "Kitchen knives have given way to pistols and sawed-off shotguns.

"We seem to be witnessing a female crime wave," she told a special symposium on violence in America.

The reasons, she said, probably involve an interaction of psychological, social, economic, political and even religious factors.

Denmark said the rise in female crime cannot be fully seperated psychologically from inner conflict and stress. And she said the fact that more women than men are reported to be suffering from some sort of mental illness suggests "a powerful link between what women are experiencing and what they are doing."

The Washington Post, February 25, 1976
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Ann Landers

THE WASHINGTON POST *Thursday, March 2[illegible], 1976*

Dear Ann Landers:

Is there relief of kind for a person with my problems? How do other people deal with it? I can't be the only one.

I am nearly 60 years old and I still cry, brawl, sob walk the floors and wring my hands because of my miserable childhood.

Never a hug or a kiss, a compliment or a kind word. It was always an order, a crack on the side of the head, a shove or a kick. We weren't spanked. We were beaten. We weren't slapped, we were pummeled.

Why can't I forget? Why do parents do such things? No sweet memories. It's torture. Am I crazy?

Dear Haunted:

No, you aren't crazy, but you do need professional help to overcome the anger and resentment that has hung on much too long.

You were an unloved, battered child. Most unloved and battered children had parents who were also unloved and battered. When you understand what their lives must have been like you will stop grieving about your miserable childhood and look outward and ahead, instead of inward and back.

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Psychological
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THE CHILD-ABUSING PARENT:

A PSYCHOLOGICAL REVIEW

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Review of professional opinions in the literature reveals that (*a*) the abusing parent was himself raised with some degree of deprivation; (*b*) the abusing parent brings to his role as parent mistaken notions of child rearing; (*c*) there is present in the parent a general defect in character structure allowing aggressive impulses to be expressed too freely; and (*d*) while socioeconomic factors might sometimes place added stresses on basic personality weakness, these stresses are not of themselves sufficient or necessary causes of abuse. A critique is made of a recent demographic survey in light of the foregoing data.

Why does a parent physically abuse his or her own child? During the past 10 years, many attempts have been made to answer this question. An extensive literature has emerged on the medical and legal aspects of the problem of child abuse since the publication of an article by Kempe, Silverman, Steele, Droegemueller, and Silver (1962) and the pursuit of child-protective laws in California by Boardman (1962, 1963). Sociologists and social workers have contributed their share of insights, and a few psychiatrists have published their findings, but surprisingly little attention has been devoted to the problem of child abuse by the psychologist. One seeks with little success for well-designed studies of personality characteristics of abusing parents. What appears is a literature composed of professional opinions on the subject.

The aim of this review is to bring together professional opinions of this decade on the psychological characteristics of the abusing parent, in order to determine from the most commonly held opinions what generalizations can be induced and thus to lay the groundwork for systematic testing of hypotheses.

DEFINITION

What is child abuse? Kempe et al. (1962) limited their study to children who had received serious physical injury, in circumstances which indicated that the injury was caused willfully rather than by accident. They coined the term "battered child" to encompass their definition. Zalba (1966), after a brief review of definitions, likewise addressed himself primarily to those cases in which physical injury was willfully inflicted on a child by a parent or parent substitute.

Because of the difficulty of pinpointing what is emotional or psychological or social neglect and abuse, and because of the extent of the literature on physical abuse alone, this review, following Kempe's and Zalba's lead, limits the term "child abuse" to the concept of physical injury to the child, willfully inflicted. The review omits studies of parents who neglect their children—emotionally, socially, or psychologically—and adults who sexually molest them.

MEDICAL AND LEGAL HISTORY

Literature on the medical and legal aspects of the problem of child abuse is extensive. The edited volume of Helfer and Kempe (1968) contains a general overview, as do the articles by Paulson and Blake (1967), Silver (1968), and Zalba (1966). Legal aspects are delineated in De Francis (1970), McCoid (1965), and the various articles by Paulsen (1966a, 1966b, 1967, 1968a, 1968b). Simons and Downs (1968) gave an overview of pat-

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terns, problems, and accomplishments of the child-abuse reporting laws. A thorough bibliography on child abuse was published by the United States Department of Health, Education and Welfare (1969).

This review is not concerned with the medical and legal aspects of the problem and refers only to those articles that gave more than a passing mention to the psychological and social determinants of parental abuse of children.

Review of the Literature

Most of the studies of child abuse are subject to the same general criticism. First, the studies that set out to test specific hypotheses are few. Many start and end as broad studies with relatively untested common-sense assumptions. Second, in most studies in this area, the researchers used samples easily available from ready-at-hand local populations, and thus the samples were not truly representative. We shall have to rely on the convergence of conclusions from various types of sampling to establish generalizations. Third, practically all of the research in child abuse is ex post facto. What is left unanswered and still to be tested is whether one can determine prior to the onset of abuse which parents are most likely to abuse their children, or whether high-risk groups can only be defined after at least one incident of abuse has occurred.

In spite of these criticisms, the studies of child abuse do give general data that can furnish hypotheses for more rigorous research design, and for a more differentiated approach to the question of why parents abuse their children.

Demographic Characteristics

In an attempt to discover whether or not various social or economic stresses make abuse more likely, many of the studies have described demographic characteristics of abusing families. Kempe et al. (1962) found in the abusing families a high incidence of divorce, separation, and unstable marriages, as well as of minor criminal offenses. The children who were abused were very young, often under one year of age. In many of the families, children were born in very close succession. Often one child would be singled out for injury, the child that was the victim of an unwanted pregnancy.

Various other studies enter figures from their own samples, generally repeating Kempe's findings (Birrell & Birrell, 1968; Cameron, Johnson, & Camps, 1966; Ebbin, Gollub, Stein, & Wilson, 1969; Elmer & Gregg, 1967; Gregg & Elmer, 1969; Helfer & Pollock, 1967; Johnson & Morse, 1968; Nurse, 1964; Schloesser, 1964; Skinner & Castle, 1969).

Elmer (1967) and Young (1964) add to Kempe's findings the factors of social and economic stress, lack of family roots in the community, lack of immediate support from extended families, social isolation, high mobility, and unemployment.

While pointing to the role that economic and social stresses play in bringing out underlying personality weaknesses, the majority of the foregoing authors caution that economic and social stresses alone are neither sufficient nor necessary causes for child abuse. They point out that, although in the socially and economically deprived segments of the population there is generally a higher degree of the kinds of stress factors found in abusing families, the great majority of deprived families do not abuse their children. Why is it that most deprived families do not engage in child abuse, though subject to the same economic and social stresses as those families who do abuse their children?

A study that sheds light on the fact that social and economic factors have been overstressed as etiological factors in cases of child abuse is that of Steele and Pollock (1968), whose sample of abusers consisted mainly of middle-class and upper-middle-class families. Though social and economic difficulties may have added stress to the lives of the parents, Steele and Pollock considered these stresses as only incidental intensifiers of personality-rooted etiological factors.

Simons, Downs, Hurster, and Archer (1966) conducted a thorough study delineating abusing families as multiproblem families in which, not the socioeconomic factors alone, but the interplay of mental, physical, and emotional stresses underlay the abuse.

Allowing that child abuse in many cases may well be the expression of family stress, Adelson (1961), Allen, Ten Bensel, and Raile (1969), Fontana (1968), Holter and Friedman (1968), and Kempe et al. (1962) considered psychological factors as of prime importance in the etiology of child abuse. There is a defect in character structure which, in the presence of added stresses, gives way to uncontrolled physical expression.

Paulson and Blake (1969) referred to the deceptiveness of upper- and middle-class abusers, and cautioned against viewing abuse and neglect as completely a function of educationally, occupationally, economically, or socially disadvantaged parents, or as due to physical or health impoverishment within a family.

If it is true that the majority of parents in the socially and economically deprived segments of the population do not batter their children, while some well-to-do parents engage in child abuse, then one must look for the causes of child abuse beyond socioeconomic stresses. One of the factors to which one may look is parental history.

Parental History

One basic factor in the etiology of child abuse draws unanimity: Abusing parents were themselves abused or neglected, physically or emotionally, as children. Steele and Pollock (1968) have shown a history of parents having been raised in the same style that they have recreated in the pattern of rearing their own children. As infants and children, all of the parents in the groups were deprived both of basic mothering and of the deep sense of being cared for and cared about from the beginning of their lives.

Fontana (1968) also viewed the parents as emotionally crippled because of unfortunate circumstances in their own childhood. The parents reacted to their children in keeping with their own personal experiential history of loneliness, lack of protection, and lack of love. Many authors corroborated the hypotheses of Steele and Pollock and of Fontana.

In a study surveying 52 men and 7 women imprisoned for cruelty to their children, Gibbins and Walker (1956) concluded that it was rejection, indifference, and hostility in their own childhood that produced the cruel parents.

Ten years later, Tuteur and Glotzer (1966) studied 10 mothers who were hospitalized for murdering their children and found that all had grown up in an emotionally cold and often overtly rejecting family environment, in which parental figures were either absent or offered little opportunity for wholesome identification when present.

Komisaruk (1966) found as the most striking statistic in his study of abusing familie the emotional loss of a significant parenta figure in the early life of the abusive parent

Perhaps the most systematic and well-controlled study in the area of child abuse, tha of Melnick and Hurley (1969), compare two small, socioeconomically and racial matched groups on 18 personality variable Melnick and Hurley found, among oth things, a probable history of emotional de privation in the mothers' own upbringing.

Further support for the hypothesis th the abusing parent was once an abused neglected child is found in Bleiberg (196 Blue (1965), Corbett (1964), Curtis (19 Easson and Steinhilber (1961), Fairburn a Hunt (1964), Fleming (1967), Green (1965 Harper (1963), Kempe et al. (1962), M Henry, Girdany, and Elmer (1963), Morr Gould, and Matthews (1964), Nurse (196 Paulson and Blake (1969), Silver, Dubl and Lourie (1969b), and Wasserman (196

In a summary statement, Gluckman (196 repeating the findings of earlier observers, up a 10-point differential diagnosis catego His main point, and the point of this sect of the review, is that the child is the fat of the man. The capacity to love is not herent; it must be taught to the child. Cr acter development depends on love, tolera and example. Many abusing parents w raised without this love and tolerance.

Parental Attitudes toward Child Rearing

In addition to concurring on the fact many abusing parents were themselves ra with some degree of abuse or neglect, authors agreed that the abusing parents s common misunderstandings with regar the nature of child rearing, and look to the child for satisfaction of their own parental emotional needs.

Steele and Pollock (1968) found that the parents in their study group expected and demanded a great deal from their infants and children, and did so prematurely. The parents dealt with their children as if older than they really were. The parents felt insecure and unsure of being loved, and looked to their children as sources of reassurance, comfort, and loving response, as if the children were adults capable of providing grown-up comfort and love.

Melnick and Hurley (1969), in their well-controlled study of personality variables, also found in the mothers severely frustrated dependency needs, and an inability to empathize with their children.

Galdston (1965) concurred that abusing parents treated their children as adults, and he added that the parents were incapable of understanding the particular stages of development of their children.

Bain (1963), Gregg (1968), Helfer and Pollock (1967), Hiller (1969), Johnson and Morse (1968), Korsch, Christian, Gozzi, and Carlson (1965), and Morris and Gould (1963) also reported that abusing parents have a high expectation and demand for the infant's or child's performance, and a corresponding disregard for the infant's or child's own needs, limited abilities, and helplessness. Wasserman (1967) found that the parents not only considered punishment a proper disciplinary measure but strongly defended their right to use physical force.

In a 1969 study, Gregg and Elmer, comparing children accidentally injured with those abused, judged that the mother's ability to keep up the personal appearance of the child when well, and her ability to provide medical care when the child was moderately ill, sharply differentiated the abusive from the nonabusive mothers.

The authors seem to agree that abusing parents lack appropriate knowledge of child rearing, and that their attitudes, expectations, and child-rearing techniques set them apart from nonabusive parents. The abusing parents implement culturally accepted norms for raising children with an exaggerated intensity and at an inappropriately early age.

Presence of Severe Personality Disorders

There has been an evolution in thinking regarding the presence of a frank psychosis in the abusing parent. Woolley and Evans (1955) and Miller (1959) posited a high incidence of neurotic or psychotic behavior as a strong etiological factor in child abuse. Cochrane (1965), Greengard (1964), Platou, Lennox, and Beasley (1964) and Simpson (1967, 1968) concurred. Adelson (1961) and Kaufman (1962) considered only the most violent and abusive parents as having schizophrenic personalities. Kempe et al. (1962), allowing that direct murder of children betrayed a frank psychosis on the part of the parent, found that most of the abusing parents, though lacking in impulse control, were not severely psychotic. By the end of the decade, the literature seemed to support the view that only a few of the abusing parents showed severe psychotic tendencies (Fleming, 1967; Laupus, 1966; Steele & Pollock, 1968; Wasserman, 1967).

Motivational and Personality Variables: A Typology

A review of opinions on parental personality and motivational variables leads to a conglomerate picture. While the authors generally agree that there is a defect in the abusing parent's personality that allows aggressive impulses to be expressed too freely (Kempe et al., 1962; Steele & Pollock, 1968; Wasserman, 1967), disagreement comes in describing the source of the aggressive impulses.

Some authors claim that abuse is a final outburst at the end of a long period of tension (Nomura, 1966; Ten Have, 1965), or that abuse stems from an inability to face life's daily stresses (Heins, 1969). Some claim that abuse stems from deep feelings of inadequacy or from parental inability to fulfil the roles expected of parenthood (Cohen, Raphling, & Green, 1966; Court, 1969; Fontana, 1964; Johnson & Morse, 1968; Komisaruk, 1966; Silver, 1968; Steele & Pollock, 1968). Others described the parents as immature, self-centered, and impulse-ridden

(Cochrane, 1965; Delaney, 1966; Jacobziner, 1964; Ten Bensel, 1963).

Some authors consider a role reversal between the spouses as a prime factor in the etiology of child abuse. A home in which the father is unemployed and the mother has taken over the financial responsibility of the family is considered a breeding ground for abuse (Galdston, 1965; Greengard, 1964; Nathan, 1965; Nurse, 1964).

Finally, there are those authors who considered low intelligence as a prime factor in the etiology of child abuse (Fisher, 1958; Simpson, 1967, 1968), although this point is disputed in the findings of Cameron et al. (1966), Holter and Friedman (1968), Kempe et al. (1962), and Ounsted (1968).

Is there a common motivational factor behind child abuse? Is there only one "type" of abusing parent? Realization that each of the above described characteristics was found to exist at least in some individual circumstances has led some authors to group together certain characteristics in clusters, and to evolve a psychodynamic within each cluster. The first major attempt at a typology was made by Merrill (1962). Because Merrill's typology is the most often quoted, it is summarized in some detail.

Merrill identified three distinct clusters of personality characteristics that he found to be true both of abusing mothers and fathers, and a fourth that he found true of the abusing fathers alone. The first group of parents seemed to Merrill to be beset with a continual and pervasive hostility and aggressiveness, sometimes focused, sometimes directed at the world in general. This was not a controlled anger, and was continually with the parents, with the only stimulation needed for direct expression being normal daily difficulties. This angry feeling stemmed from conflicts within the parents and was often rooted in their early childhood experiences.

The second group Merrill identified by personality characteristics of rigidity, compulsiveness, lack of warmth, lack of reasonableness, and lack of pliability in thinking and in belief. These parents defended their right to act as they had in abusing their child. Mothers in this group had marked child-rejection attitudes, evidenced by their primary concern with their own pleasures, inability to feel love and protectiveness toward their children, and in feelings that the children were responsible for much of the trouble being experienced by themselves as parents. These fathers and mothers were extremely compulsive in their behavior, demanding excessive cleanliness of their children. Many of these parents had great difficulty in relaxing, in expressing themselves verbally, and in exhibiting warmth and friendliness.

Merrill's third group of parents showed strong feelings of passivity and dependence. Many of these parents were people who were unassuming, reticent about expressing their feelings and desires, and very unaggressive. They were individuals who manifested strong needs to depend on others for decisions. These mothers and fathers often competed with their own children for the love and attention of their spouses. Generally depressed, moody, unresponsive, and unhappy, many of these parents showed considerable immaturity.

Merrill's fourth grouping or cluster of personality characteristics included a significant number of abusing fathers. These fathers were generally young, intelligent men with acquired skills who, because of some physical disability, were now fully or partially unable to support their families. In most of these situations, the mothers were working and th fathers stayed at home, caring for the children. Their frustrations led to swift an severe punishment, to angry, rigid discipline

Two further attempts at classification, Delsordo (1963) and Zalba (1967), with sligh modifications, can be reduced to Merrill categories.

The use of categories seems simple, unifying, and time saving. If further work can done in refining the categories, validatin them in field research, perhaps they or simil clusters shown to be empirically valid can used as an aid in the determination of hig risk parents.

In this section, we have seen a conglomera picture of parental motivational and perso ality variables, with one author's attemp cluster the characteristics into a workal unity. One basic fact of agreement emer from the studies in this section. The auth feel that a general defect in character—fr whatever source—is present in the abusing parent allowing aggressive impulses to be expressed too freely. During times of additional stress and tension, the impulses express themselves on the helpless child.

CRITIQUE OF A SURVEY

Of the studies surveying the demographic characteristics of families in which child abuse has occurred, the most extensive in scope was the national survey undertaken by Gil (1968a, 1968b, 1969).[2] In 1969, Gil reported that the phenomenon of child abuse was highly concentrated among the socioeconomically deprived segments of the population. Concluding that "physical abuse is by and large not very serious as reflected by the data on the extent and types of injury suffered by the children in the study cohort [p. [illegible]]," Gil placed his intervention strategy in the general betterment of society. For Gil, the cultural attitude permitting the use of physical force in child rearing is the common core of all physical abuse of children in American society. Since he found the socioeconomically deprived relying more heavily on physical force in rearing children, he recommended systematic educational efforts aimed at gradually changing this cultural attitude, and the establishment of clear-cut cultural prohibitions against the use of physical force as a means of rearing children. He viewed this educational effort as likely to produce the strongest possible reduction in the incidence and prevalence of physical abuse of children.

For Gil, child abuse is ultimately the result of chance environmental factors. While admitting to various forms of physical, social, intellectual, and emotional deviance and pathology in caretakers, and in the family units to which they belong, Gil stressed a global control of environmental factors as the solution to the problem of child abuse. He suggested: (*a*) the elimination of poverty from the midst of America's affluent society; (*b*) the availability in every community of resources aimed at the prevention and alleviation of deviance and pathology; (*c*) the availability of comprehensive family planning programs and liberalized legislation concerning medical abortions, to reduce the number of unwanted children; (*d*) family-life education and counseling programs for adolescents and adults in preparation for and after marriage, to be offered within the public school system; (*e*) a comprehensive, high-quality, neighborhood-based national health service, to promote and assure maximum feasible physical and mental health for every citizen; (*f*) a range of social services geared to the reduction of environmental stresses on family life; and (*g*) a community-based system of social services geared to assisting families and children who cannot live together because of severe relationship problems. Gil's ultimate objective is "the reduction of the general level of violence, and the raising of the general level of human well-being throughout our entire society [p. 863]."

While one must praise the efforts of the Gil study in data collection, and the ultimate objective of reducing the general level of violence and raising the general level of human well-being in our entire society, one cannot help but feel that Gil did not address himself to the question of child abuse. If there really does exist as strong a link as Gil suggests between poverty and physical abuse of children, why is it that all poor parents do not batter their children, while some well-to-do parents engage in child abuse? Eliminating environmental stress factors and bettering the level of society at all stages may reduce a myriad of social ills and may even prove effective, indirectly, in reducing the amount of child abuse. But there still remains the problem, insoluble at the demographic level, of why some parents abuse their children, while others under the same stress factors do not.

Other authors throughout the decade have allowed for the types of services outlined by Gil, but less globally and in a manner less disregarding of parental personality factors. That raising the general educational and financial level of families that are socioeconomically deprived is of long-range value in the lessening of the prevalence of child abuse is generally agreed upon, and finds support throughout the literature. However, most of the authors explicitly caution against considering abuse, as does Gil, as a function solely of educational, occupational, economic, or social stresses. This point is made by Adelson (1961), Allen et al. (1969), Elmer (1967), Fontana (1968), Helfer and Pollock (1967), Holter and Friedman (1968), Kempe (1968), Kempe et al. (1962), Paulson and Blake (1967), Silver et al. (1969a, 1969b), and Steele and Pollock (1968).

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[2] Gil's book reporting his national findings (*Violence against children: Physical child abuse in the United States.* Cambridge, Mass.: Harvard University Press, 1970) appeared after the present review was accepted for publication. Although the book offers greater detail, the findings and conclusions are identical to those in the cited references.

The great majority of the authors cited in this review have pointed to psychological factors within the parents themselves as of prime importance in the etiology of child abuse. They see abuse as stemming from a defect in character leading to a lack of inhibition in expressing frustration and other impulsive behavior. Socioeconomic factors sometimes place added stress on the basic weakness in personality structure, but these factors are not of themselves sufficient or necessary causes of abuse.

CONCLUSIONS

The purpose of this review has been to bring together the published professional opinions on the psychological characteristics of the abusing parent, in order to determine from the most commonly held opinions what generalizations can be induced, and thus to lay the groundwork for more systematic testing of hypotheses.

The psychologist, both as a specialist in the functioning of the human as an individual, and as a scientist trained in research methodology, is in a unique position to test the hypotheses raised by professionals in the fields of medicine and social work, in the study of the personality characteristics of the abusing parent.

Certainly, one would hope that research can eventually develop criteria to distinguish those inadequate parents who, with professional help, can meet the needs of their children, from those who cannot. We need eventually to be able to identify the high-risk families prior to the onset of abuse, but should be satisfied for the time being if we can help determine after the fact of abuse which families must receive the most attention to assure the further safety of their child.

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VIOLENCE IN OUR SOCIETY

VIOLENCE IS THE NAME we give to the more extreme forms of aggression that we consider destructive and wrong. There is much of it in our society. There is much of it all over the world, and we deplore it. But rather than just deploring it further, repeating the common phrase, "We've got to stop it," I would like to describe a few of my ideas, shared by some others, about why violence persists in our culture, why it is expressed the way it is, and when it is.

At the outset, I should say that I am one of those who believes that there is such a thing as an instinctive drive or urge toward aggression. All of us human beings share an urge toward action that can become either constructive or destructive. Aggression is part of our biological heritage. In the relatively short time of our evolution as homo sapiens, we have not had time to mutate free of the aggressive drive that is so characteristic of all subhuman primates and lower animals. It is doubtful if we could survive without aggression. Even if we did, we would lose much of our ability to be creative and progressive.

During my own childhood in those quiet, post-Victorian years of the early part of this century, many cautionary tales and poems were used for the admonition of children. One of these little poems that my Quaker grandmother and my maiden aunts often quoted to my brothers and me went as follows: "Let dogs delight to bark and bite, for 'tis their nature to; let lions and tigers growl and fight, for God hath made them so. But children, you should never let your angry passions rise; your little hands were never made to tear each other's eyes." Now, I think it was quite obvious to my brothers and me that no matter what was said, our hands were made quite well to use to tear eyes. But there was a very clear commandment that we should not do this. I believe it was equally obvious to us that it was quite possible to use our hands to hit and whack and throw rocks at each other, and prohibitions against these things had to be added. I think maybe ever since that time I've been vaguely interested in the fact that human beings are natively capable of being quite aggressive, and that the problem is very much one of the manner in which such impulses are channeled or directed. In what ways do we have permission to discharge our aggressive drives?

In recent years we have been quite disturbed by the assassination of John Kennedy, Robert Kennedy, and Martin Luther King. Since the United States began, not quite two centuries ago, four presidents have been killed and three others shot at but not killed. We are all very much distressed by this evidence of violence. Let us look for a minute at a corresponding number of years in the history of Rome, covering the period from Julius Caesar through the reign of the Emperor Hadrian. In our period, we have had 37 presidents. In the corresponding period in Rome, 21 men assumed the leadership of government. Of those 21, 8 were murdered, 4 committed suicide, 8 died a natural death. One man, Cassius, does not quite fit into this classification because, after his defeat by Marc Antony, he ordered his own freed men to kill him, a curious situation of suicide by directed murder. Compared to those ancient Romans, much of whose culture we inherit, we are doing better, but the same patterns still exist. Why did Brutus and Cassius murder Caesar? These two men had their own individual strivings and yearnings for power, but in addition they had the strong conviction that there were certain ideals of the old republic that should be lived up to and maintained. Caesar betrayed the ideals they believed in, so they considered him an evil man who should be destroyed.

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Why did John Wilkes Booth kill Lincoln? Because he had a deep belief in the rightness of the Southern cause, in the Southern ideals and in the

Confederacy. He killed Lincoln to avenge himself and the South against the evil he believed Lincoln had done against their rights.[1] Why did Guiteau kill Garfield? He was a disappointed office-seeker to be sure. He was also a member of a political group called "the stalwarts," who were very much against Garfield, and who felt that he had not recognized their rights and their privileges. Therefore, Garfield personified the evil that Guiteau thought existed, so he killed him.[2] Leon Czolgosz assassinated McKinley. Czolgosz was a member of a group of anarchists whose ideals and sense of duty led them to assassinate rulers.[3]

Theodore Roosevelt, Franklin Roosevelt, and Harry Truman were shot at by people whom we called "fanatics." We disagree completely with their behavior and are horrified by it, yet we must realize that from their standpoint they were following the highest of ideals and duty.

It is this pattern of the discharge of aggression in violent forms with a sense of rightness or even righteousness that I want to accent. This pattern has a long and very frightening history in our culture. Let me cite a few examples. Late in the 10th century, King Olaf Tryggvesson converted the Norwegians to Christianity. How did he do it? He took his army out through the country and offered the villagers two choices: either to become Christians or have their heads chopped off. Is this much different from the present groups in our society who say, "You must either follow our ideals and demands--what we believe is right--or we will riot, pillage, and destroy?" Somewhat later the Crusaders, carrying the banner of God and the Church with the noble purpose of liberating the Holy Land, killed thousands of infidels and Saracens. In the name of holiness and righteousness, the Spanish Inquisition tortured and burned the heretics. In the name of goodness and their own purity, our New England Puritans burned witches at Salem. The Ku Klux Klan, absolutely sure of its white Protestant superiority, lynched Negroes and attacked Catholics. The Nazis, convinced of their own nobility, purity, and superiority, tried hard to eliminate the Jews. In our own lifetime we have seen Americans, under the ideals of freedom, democracy, and making the world safe for peace, go out with great pride and joy and bravery and kill Germans, Japanese, North Koreans, and Chinese. Only recently, during the Vietnam war, have a significant number of people begun to question our rightness and our righteousness in following these old patterns of killing in the name of goodness. Only recently has the righteousness of the law, and the right of the law to put people to death in gas chambers, in electric chairs, and on the gallows—only recently has this become questioned and out of style. But there are still many of us who believe that these types of behavior are very right and very good and very necessary.

Margaret Mead, the anthropologist, wrote clearly in this area. She says, "We know of no human society that does not distinguish between permissible and unpermissible killing. To kill a human being in forbidden ways is *murder;* to kill the trespasser, the enemy, is approved, or even enjoined."

It seems obvious that individuals as well as various cultural and social groups tend to use aggression and violence that they consider good or right to enforce their good and right standards. Even nominally peaceful people use this mechanism. Let me turn again to the Quakers for an example. A Quaker woman named Hannah Whitall Smith was a devout, peace-loving woman brought up near Philadelphia, where she married and raised her children, and later moved to England where she lived the rest of her life. She often gave talks on religious subjects and was a very active member of the British Women's Temperance Union. Like many other Quakers she was very much interested and active in improving the status of women. Not quite 100 years ago she wrote in a letter to a friend: "Girls have a right to a college education. They should be made to get it, even at the point of a bayonet." Several months ago, a newspaper item under a San Francisco dateline quoted Governor Ronald Reagan to the effect that he would keep San Francisco State College open, even if it required the use of bayonets. In these statements of Hannah Smith's and Governor Reagan's, we see clearly demonstrated the tendency to use force to implement a perfectly good ideal. Not openly expressed but certainly implied is a lack of consideration or empathy or understanding for those toward whom this force is directed. I believe this is true in all episodes of violence. The perpetrator of violence does not consider the wishes, abilities, ideas, or anything else about the object of his aggression.

My own thoughts on the subject of aggression have been stimulated and developed largely during the last eight years, during which we have been working on a problem that has been publicized as the "Battered Child Syndrome." This unusually interesting form of behavior involves not only the discharge of aggression against other members of our own species, but the release of very destructive aggression by adults toward their own offspring. In milder forms it is extremely prevalent—common throughout our culture, not only in America but throughout all of Western culture. In its most severe forms, child abuse is distressingly frequent. As far as we can estimate, something like 40,000 children are seriously injured by their parents each year in the United States. About a third of them are under age three. It is with this latter group of infants and very small children that we have done most of our work.

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[1] Booth wrote in his diary, "Our country owed all her troubles to him, and God simply made me the instrument of punishment."

[2] Guiteau wrote about Garfield, "His election was an act of God. His removal was an act of God." (His removal) "will save the Republic."

[3] Czolgosz said, (I) killed the president because he is "an enemy of the people, the good working people

What happens between parent and child? I'd like to refer back again to my friend, the Quaker lady. Just 104 years ago, in February, 1866, Hannah Whitall Smith wrote to a friend as follows:

> "It is just perfectly wonderful to have two babies, and I only wish it was *three*. Mary is developing so exactly as one's fondest hopes could desire that my heart almost trembles with the weight of happiness. Logan and I had our first regular battle today. . . . I whipped him until he was actually black and blue, and until I really *could not* whip him anymore, and he never gave up one single inch. However, I hope it was a lesson to him. He is going to get it over again for screaming."

Her baby, Logan, was 3½ months old. In her own circle, one of the upper circles in England, she was thought of as "a saint and a sage." Her friend, William James, shared this view. Her younger daughter, Alys, was Bertrand Russell's first wife, and Russell has written that he divorced Alys because she was too much like her mother.

Mrs. Smith expected her babies to live and behave in such ways as to fill her heart with joy. She didn't seem to be paying very much attention to how the babies felt—what they wanted to do, what they could do, or could not do. She punished Logan for not behaving well, and to teach him a lesson. It is clear she had no doubts about the rightness of what she was doing.

Let me give you some further examples. Two little boys, age five months and 18 months, were brought into the Colorado General Hospital with multiple bruises, lacerations, and fractures. Their father, Henry J., who had injured them, told us: "Children have to be taught respect for authority and be taught obedience. I would rather have my children grow up afraid of me and respecting me than loving me and spoiled." He had injured the children during routine disciplinary punishment intended to teach them good behavior.

A mother, Holly T., whose five-month-old baby suffered a fractured skull and a fractured pelvis, told us how children have to be taught to be obedient, to respond to parental demands, and to take care of themselves and not expect too much from their parents. She said that her little baby, age 5½ months, was lazy and stubborn, and therefore needed discipline.

These are typical stories. Despite many individual variations, abusive parents constantly refer to three main themes. First, they expect an unusually high level of performance from their children, based upon their conviction that certain things are right, necessary, and must be carried out. Second, the parents firmly believe physical punishment to be a necessary and correct form of discipline to be used to implement their high standards. Third, they inevitably totally disregard their infant's own helpless state and inabilities as well as his desires and needs.

In working with parents who have abused their children, we find that they were brought up very much the same way. They are repeating with their own children the child-rearing practices of their own parents. Henry J. recalls that his father frequently beat him and his brothers with straps, sticks and boards, and remembers his father often saying, "I'm going to teach you boys to respect authority. I don't want you to grow up to be juvenile delinquents." Holly told us that her mother tells her, "You better teach those kids to behave better. Sammy ought to have his butt blistered every time he turns around."

Not rarely the type of punishment inflicted by the parents has a very specific significance. Another man, who had seriously burned the palms of the hands of his two little boys as a lesson-teaching punishment for playing with matches, said to us, "That's the right and best way to deal with things. My mother burned my hands when I played with matches." So we see a pattern of parents repeating toward their own children the aggressive, violent behavior that was expressed toward them when they were little. We have had the privilege sometimes not only to see the abusive parents, but to talk with the abusive parents' own parents and their grandparents, and we have learned that this particular style of child rearing passes very easily through at least three or four generations.

I have been writing about that part of our mental apparatus that we analysts call the superego, the structure, partly unconscious, that carries our deep convictions of what is good and bad, right and wrong, and the categorical imperatives of should and should not, must and must not. The superego, which can also be described as a combination of our ideals and our conscience, has a great deal to do with our behavior—into what actions during our lives we direct our basic instinctual drives and our desires. Hence, it largely determines what channels of aggressive discharge we find permissible, desirable, or even obligatory.

Our superegos begin to be formed very early in our lives, as we are indoctrinated with the general morals and ethics of our culture, especially as these are modified and expressed through the particular character, example and commands of our own parents. Although we are born with a lot of innate abilities, we have to learn how to handle them. We are born, obviously, with an ability to speak and to develop language. But we very soon learn that if we expect to be understood in our culture we had better speak English, and if we want the full love and approval of our parents, we must learn to speak with their particular intonation and accent. We must learn to say "please" and "thank you," and never to say naughty, dirty words within earshot of parents. Long before we go to school, we have learned many rules and standards of behavior in our homes. We have learned that we must use toilets and not wet our pants; we must not lie, we must not use other people's belongings without their permission, and we must come to dinner when we are called.

All this is accomplished largely through two means of indoctrination. One is the promise of love and approval if one accepts these standards and follows them, the other is the threat of punishment if one does not behave properly. These methods are extremely effective in our earliest childhood, and they are somewhat effective throughout our lives. We all know that it is possible to reorient people as to their aggressive discharges. We can even take adults—young men who have never thought of killing and in fact have been very much against it—and put them in the army and teach them to kill. A complete reversal takes place. Now they get rewards for killing. If they do enough of it, they get a gold medal and are heroes. If they refuse to kill, they will be dishonored, court-martialed and punished. So these methods are very effective in teaching us what we had better do, and what we had better not do.

Many forms of violence have their origin in the early experience of children, definitely related to the particular subculture and families in which they grow up. If one grew up in certain types of Southern families, he would know that it was very wrong to kill other white men, but he might believe on the other hand that it was not only permissible but often admirable to lynch or in other ways kill Negroes. If one grew up in a Negro ghetto, he might very well very early in life be convinced of the fact that it was an admirable duty to hate policemen and to express aggression against white people in general. If one is a loyal Arab born in Cairo, he will feel correct and justified in attacking Israelis. On the other hand, for one born in Israel, it is permissible to attack Arabs. Our own pioneer ancestors considered it a righteous duty to kill the naked savage Indians who had the temerity to object to the fact that we took their land away from them.

We must pay attention to the fact that patterns of violence and the channels of discharge of violence in our culture are very often specifically directed by that part of our psyche that we call the conscience and that is the seat of our moral convictions. We are all brought up with various kinds of superegos, and what may seem entirely wrong to one of us will seem entirely right to another. But this early instigation in this very important psychic structure of patterns of aggression is one of the most important mechanisms for the transmission of violence in our culture and the perpetuation of certain patterns picked out among others for the legitimate discharge of aggression, and the legitimate objects for our hatred and our attack.

In addition to this mechanism of the transmission of violence by the inculcation in the growing child of certain cultural and familial standards, there is another mechanism for the instigation and transmission of aggression. It is much more subtle—much more individual. As analysts, we call it "identification with the aggressor." It is accomplished entirely within the individual's own psyche and without the pressure of outside command. When a child feels attacked, he is little and helpless and cannot fight back. In an effort to reestablish some sense of mastery or control and to find some way to discharge his angry feelings, he may decide to become like the one who has attacked him and then direct his aggression against the outside world in a similar way. In this way, he can avoid that unpleasant feeling of being the passive, helpless subject of attack and can become the strong attacker himself.

Let me give you a somewhat humorous example of this. I knew a little boy, Tim, who had had a very good relationship with his pediatrician except on those occasions when he had to get a shot. Then he felt very much put upon, hurt and resentful. When he was three, a new baby brother arrived. He had somewhat mixed feelings toward this baby brother—an interesting, nice kid, but he did disrupt the relationship Tim had had with his mother up to that time. Mother took the new baby to the pediatrician, and Tim went along and watched while the new baby was getting some shots. Tim looked slightly pleased during this time. And afterwards, when the baby had stopped crying and they were leaving for home, Tim said to his mother, "Mom, do you know what I'm going to be when I grow up?" She said, "No, Tim, what are you going to be?" He replied, "I'm going to be a pediatrician and hurt babies!" In this way, Tim found a way to channel his feelings of aggression and to avoid his own feelings of fear and helplessness. We do not need to worry about him, however. Now, several years later, he and his brother are the best of friends, and Tim is full of the joy of life and very much involved with natural history, mathematics and music.

In other children, the mechanism of identification with the aggressor profoundly influences their later character development and later behavior, an effort apparently related to the frequency and severity of the attack to which the growing child is subjected. The infant or young child who sees recurrent serious expressions of violence in his own family and is himself often the recipient will inevitably grow up to follow parental example and admonition and believe in violence as a useful way of life and a useful way to solve problems. He will also, in an effort to gain some measure of self-protection and mastery, identify very strongly with the aggressor and develop a very deep-set pattern in himself of discharging aggression against the outside world in order to manage his own insecurities. The potency of this mechanism of identification with the aggressor in such children is markedly enhanced by the fact that the parent is the aggressor, the same parent who is the model for much of the rest of the superego's formation.

From our studies with abusive parents, we have learned that the pattern of severe discipline and abuse of children relates directly to the abusive parent's own very early childhood experience, passing inevitably from generation to generation. This particular form of violence perpetuates itself in our culture, largely due to these supergo mechanisms. Violence is discharged under the banner of doing what is right, good, and necessary. We do not know how much this culturally prevalent pattern of child abuse has to do with other patterns of violence, but we do have some interesting bits of information to suggest some kind of relationship—certainly not a one-to-one cause and effect, but certainly something close to it.

Some years ago, Duncan, *et al.* in Minnesota studied a series of six convicted first-degree murderers whose parents were also available for study. In working with this group, they found that four ~~three~~ of these six murderers had been seriously abused and beaten by their parents in very early infancy and childhood. Further, Drs. Satten and Rosen, at the Menninger Clinic in Topeka, reported investigations of four men who had murdered without apparent motive. All four of these men had experienced extreme parental violence during their childhoods. In an Eastern city, a consecutive series of 100 juvenile offenders, in a not yet validated pilot study, was interviewed by social workers and psychiatrists. Over 80 per cent of these juvenile offenders gave a history of having been subjected to physical abuse at the hands of their parents during childhood. Approximately 40 per cent could recall having been knocked unconscious by one or the other parent. I am not sure what to make of this, except that it warrants our most serious attention.

I know personally of one case of a 16-year-old boy, son of a professional man of a highly respected family in the community. This boy murdered his mother and his father. From early infancy on he had been physically attacked by both of them. Sometimes during the more severe beatings, one parent would take turns holding him while the other did the beating, a practice known and approved of by the grandparents.

I believe most of us would gain some sense of comfort, although it would be a false one, if we could say that these perpetrators of violence suffered from some sort of serious mental aberration. To our dismay, however, we find that most of them fall within what we call the average "normal" range of human character and behavior. It would be much easier if we could call them insane. We are distressed to find that by our standards they are sane and that sane people are dangerous.

The case of Adolph Eichmann illustrates this point. All of us react with horror at the mass murders that Eichmann supervised at Auschwitz and elsewhere, yet the psychiatrist who examined him during his trial found him sane. His sanity is the most frightening part about the whole thing. Adolph Eichmann was the product of a strong, authoritarian element in German culture in which obedience to the orders of superiors is an obligation and a virtue. He testified that he was merely being a good civil servant, shuffling the papers across his desk, and carrying out the orders of his superiors. Although we are aghast at what he did, we must face the fact that he was carrying on his work in perfect consonance with the dictates of his superego. In his own context, he was a very moral man. If Eichmann had told the psychiatrist that he had heard the voice of God telling him to kill the Jews, the psychiatrist would have pronounced him insane. However, since he was just listening only to the voice of his own conscience, the echoes of the parental commands of his own childhood and the reality voices of the orders of his superiors, he is just like the rest of us. He is sane.

We have seen a similar phenomenon in those parents who seriously injure their infants and small children. For the most part they do not show what we would call a normal or appropriate or expected sense of guilt over their actions. They have followed the dictates of their consciences and have done only what is right and necessary by their standards and, hence, could not possibly feel guilty.

We have heard quite a lot about "law and order" in recent months. We all want law and order and a reasonable degree of peace and amity in our lives. Yet, in a dilemma, we walk a tightrope, not at all sure how we can keep the peace without using violence. Our law enforcement agencies, ably equipped to be violent, often undertake violent actions under the aegis of necessity and of righteous enforcement of the law. The confrontations occurring in Chicago two summers ago are but one example of this. But as we look into these episodes of violence, we see that all the participants—the police, the students, the activists, all—claim that they acted out of necessity and in the service of perfectly valid ideals.

The law provides a system for making judgments of who is right and who is wrong and for ordering punishment for the wrong-doer. Most of us accept and agree with these concepts of the law as essential parts of our culture from antiquity up to the present. We can, however, question the appropriateness of our philosophy and procedure in the law, particularly in relation to violence. Does the system of punishment for violent behavior solve the problem? From a purely practical standpoint we find that the system does not work. Statistics show that 70 per cent of the inmates of our prisons are repeaters. In other words, a previous experience with punishment has not prevented recurrence of their anti-social actions. Why is this? Is our legal system of punishment defective? Are we not giving enough punishment? Do we lack rehabilitation facilities in the prisons, or does being subjected to punitive actions reinforce some of the aggressive tendencies of the offender? None of these questions has a clear answer. I would like to tell you, however, what happens when abusive parents experience the process of the law.

Henry J., to whom I have already referred, came up for trial for child abuse, with the foolish charge of "attempt to murder with a deadly weapon." The deadly weapons, a stick and a wooden spoon, did not provide proof of intent to murder because, as Mr. J. said, he was only doing what he had to do to discipline his children and to bring them up properly. During the selection of the jury for his trial, ten of the first 12 people drawn out of the hat for jury duty were challenged and dismissed by the district attorney because they said that they, too, used sticks and belts to discipline their children. Henry pleaded guilty, and was sent to the penitentiary for three years. His children were taken away from him and put out for adoption. I visited him in the penitentiary several times—every six months or so—certainly not enough to do him any good therapeutically, but sufficient to keep track of him. I was one of the few people whom he possibly accepted as a friend and whom he trusted. We talked about what he would do when he was released from the penitentiary. Would he come to Denver to see me and to talk some more? He said, "No, as soon as I get out of here, I'm going to go and pick up Patsy—we're going to get in the car and get out of this damn state—and we're going to go some place where we can raise our children the way we want to." This, of course, meant more beaten children in the future. I have not heard from Henry since then. We did learn, however, that one of his brothers had also been charged with child-beating in Nebraska. You will recall that Henry and his brothers had experienced similar beatings as children.

Let me describe another man, Fred M., who injured his three-year-old stepdaughter. Fred, of German ancestry, had married the mother and taken on this little girl. Fred disapproved of his wife's somewhat disorganized way of living—she was something of an artistic, Bohemian type. He thought his new family needed shaping up a bit, so he had his three-year-old girl meet him every evening as he came home from work. He would knock on the door; the little girl would open it and would have to say, "Good evening, sir, won't you come in, sir, may I have your hat, sir?" Because she couldn't always remember to do this right, he severely punished her. One evening he went further; he picked her up, shook her violently, and hit her on the head. She came to the hospital with retinal hemorrhages, blindness and a left-sided paralysis. This father came to trial, too, before a jury and was acquitted. The jury and the judge accepted his defense that he had only done what was necessary to discipline his child. He was teaching her the good behavior that she needed to learn. After all, he had not used any deadly weapon on her, not even a stick. He had only used his hands, and that is within the parental right. Having received full approval for his behavior by the legal area of our society, Fred is now inaccessible to rehabilitative measures. He is justified in his beating behavior.

These two cases typically represent the two opposite possible outcomes in a child abuse charge—innocence or guilt. The parents' involvement in the legal process, whether the court rule guilt or innocence, reinforces the very aggressive, abusive pattern that led to the difficulty in the first place.

We have found in working with these parents that we can reach them only by being non-judgmental, non-critical, and considerate of *them*. These people have never believed that anybody, including their own parents, ever thought anything of them. They were always subjected to ideas of right and wrong and the expectation of punishment. Our method of treatment, however, has been most effective. We have had very good results with a great number of parents by protecting them from this old system of "crime and punishment," intended to create good behavior. One of our patients, who seriously abused her two adopted children, responded especially well to this kind of treatment, as did her husband, and now operates a licensed foster care home in Denver.

I present no panacea for the problem of violence in our culture. As I indicated at the outset, I wish only to call attention to a concept that I think has been too much bypassed in our study of violence. I refer to the concept that our moral convictions, our superegos, not only give us permission to be violent, but give us great approval for violence expressed in certain directions. These same patterns of violence we then transmit to our children in their earliest, most formative years. We should pay much more attention to the ideals and categorical imperatives that we teach our infants and children. Education during youth and adulthood is important, but we must recognize that the most potent controls and directions of aggression and of violence are those that we learned at our parents' knees. If we are really to understand the mechanisms of violence and how to control it in our culture, we must pay attention much more than we have in the past to those moral forces within us that tell us to direct violence in certain ways, and that enable us all to do evil under the guise of doing good. We must not take it for granted that so-called moral forces of good are always and ultimately really for the good of people. As a matter of fact, I have become increasingly suspicious when people talk about goodness and rightness. I am almost ready to join with Henry David Thoreau, who said, "If I knew for a certainty that a man was coming to my house with a conscious design of doing me good, I would run for my life."

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UNIT V

The Problem of Child Maltreatment

V. THE PROBLEM OF CHILD MALTREATMENT

--- Can It Be Defined?

UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One (for Generalizations A, B, and C)

THE STUDENT WILL BE ABLE TO IDENTIFY THE INDIVIDUAL AND SOCIETAL PROBLEM OF CHILD MALTREATMENT.

Generalizations for Unit V

A. Child maltreatment may be described as circumstantial.

B. Child maltreatment may be described as incidental.

C. Child maltreatment may be described as intentional.

Performance Objectives for Generalizations A, B, and C

A 1. STATE the meaning of the term circumstantial child maltreatment.

2. DESCRIBE circumstantial child maltreatment in relation to dysfunctions within society.

3. DESCRIBE circumstantial child maltreatment in relation to dysfunctions within the family.

4. EXPLAIN the relationship of circumstantial child maltreatment to dysfunctions within the individual.

5. PREDICT the probability of circumstantial child maltreatment in relation to individual ability to cope with stress.

B 6. STATE the meaning of the term incidental child maltreatment.

7. DESCRIBE incidental child maltreatment in relation to dysfunctions within society.

8. DESCRIBE incidental child maltreatment in relation to dysfunctions within the family.

9. EXPLAIN the relationship of incidental child maltreatment to dysfunctions within the individual.

10. PREDICT the probability of incidental child maltreatment in relation to individual ability to cope with stress.

C 11. STATE the meaning of the term intentional child maltreatment.

12. DESCRIBE intentional child maltreatment in relation to dysfunctions within society.

13. DESCRIBE intentional child maltreatment in relation to dysfunctions within the family.

14. EXPLAIN the relationship of intentional child maltreatment to dysfunctions within the individual.

15. PREDICT the probability of intentional child maltreatment in relation to individual ability to cope with stress.

Instructional Objective Two for Generalization D

THE STUDENT WILL BE ABLE TO STATE THE PROVISIONS OF FEDERAL, STATE, AND LOCAL CHILD MALTREATMENT LAW.

Generalizations for Unit V. (Cont'd)

D. Child Maltreatment -- whether circumstantial, incidental, or intentional -- is defined by law.

Performance Objectives for Generalization D

1. DESCRIBE briefly the chronology and extent of child maltreatment legislation in the U.S.
2. STATE the provisions of the federal Child Abuse Prevention and Treatment Act of 1974.
3. STATE the provisions of the state laws for a) abuse and b) neglect.
4. COMPARE the state law with the local law for a) abuse and b) neglect.
5. DESCRIBE the local reporting process for a) abuse and b) neglect.

UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One

The student will be able to identify the individual and societal problem of child maltreatment.

Performance Objectives for Generalization A

1. STATE the meaning of the term circumstantial child maltreatment.
2. DESCRIBE circumstantial child maltreatment in relation to dysfunctions within society.
3. DESCRIBE circumstantial child maltreatment in relation to dysfunctions within the family.
4. EXPLAIN the relationship of circumstantial child maltreatment to dysfunctions within the individual.
5. PREDICT the probability of circumstantial child maltreatment in relation to individual ability to cope with stress.

Generalization A

CHILD MALTREATMENT MAY BE DESCRIBED AS CIRCUMSTANTIAL.

Sample Content

1. Circumstantial child maltreatment; i.e., child maltreatment belonging to, consisting in, or dependent upon circumstances
2. Circumstancial child maltreatment viewed in relation to dysfunctions within society
3. Circumstantial child maltreatment viewed in relation to dysfunctions within the family
4. Circumstantial child maltreatment viewed in relation to dysfunctions within the individual
5. Circumstantial child maltreatment viewed in relation to individual ability to cope with stress

UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One

The student will be able to identify the individual and societal problem of child maltreatment.

Performance Objectives for Generalization B

6. STATE the meaning of the term incidental child maltreatment.
7. DESCRIBE incidental child maltreatment in relation to dysfunctions within society.
8. DESCRIBE incidental child maltreatment in relation to dysfunctions within the family.
9. EXPLAIN the relationship of incidental child maltreatment to dysfunctions within the individual.
10. PREDICT the probability of incidental child maltreatment in relation to individual ability to cope with stress.

Generalization B

CHILD MALTREATMENT MAY BE DESCRIBED AS INCIDENTAL.

Sample Content

1. Incidental child maltreatment; i.e., child maltreatment occurring merely by chance or without intention or calculation
2. Incidental child maltreatment viewed in relation to dysfunctions within society
3. Incidental child maltreatment viewed in relation to dysfunctions within the family
4. Incidental child maltreatment viewed in relation to dysfunctions within the individual
5. Incidental child maltreatment viewed in relation to individual ability to cope with stress

UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One

The student will be able to identify the individual and societal problem of child maltreatment.

Performance Objectives for Generalization C

11. STATE the meaning of the term intentional child maltreatment.
12. DESCRIBE intentional child maltreatment in relation to dysfunctions within society.
13. DESCRIBE intentional child maltreatment in relation to dysfunctions within the family.
14. EXPLAIN the relationships of intentional child maltreatment to dysfunctions within the individual.
15. PREDICT the probability of intentional child maltreatment in relation to individual ability to cope with stress.

Generalization C

CHILD MALTREATMENT MAY BE DESCRIBED AS INTENTIONAL.

Sample Content

1. Intentional child maltreatment; i.e., child maltreatment which is done by intention or design
2. Intentional child maltreatment viewed in relation to dysfunctions within society
3. Intentional child maltreatment viewed in relation to dysfunctions within the family
4. Intentional child maltreatment viewed in relation to dysfunctions within the individual
5. Intentional child maltreatment viewed in relation to individual ability to cope with stress

Suggested Classroom Activities and Procedures for Performance Objectives (A) 1-5; (B) 6-10; (C) 11-15

1. Prepare students for understanding the problem of child maltreatment through in-depth study of Units I, II, III, and IV.
2. Review Unit I The Phenomenon of Child Maltreatment and Unit II The Nature of Child Maltreatment.
3. Introduce Generalizations V A, V B, and V C; and write on board for students.
4. Clarify student understanding of the terms circumstantial, incidental, and intentional, using a variety of teaching-learning techniques.
5. Develop Generalizations V A, V B, and V C Sample Content 1 through 3 for each, utilizing I.6 and selected case histories from Unit II.
    a) Circumstantial child maltreatment viewed in relation to
        (1) Dysfunctions within society
        (2) Dysfunctions within the family
    a) Incidental child maltreatment viewed in relation to
        (1) Dysfunctions within society
        (2) Dysfunctions within the family
    b) Intentional child maltreatment viewed in relation to
        (1) Dysfunctions within society
        (2) Dysfunctions within the family
6. Review Unit III The Episode of Child Maltreatment and Unit IV The Psychodynamics of Child Maltreatment.
7. Develop Generalizations V A, V B, V C Sample Content 4 for each, utilizing I.6, II.3, III.4, III.6.

a) Circumstantial child maltreatment viewed in relation to dysfunctions within the individual (caretaker or child)

b) Incidental child maltreatment viewed in relation to dysfunctions within the individual (caretaker or child)

c) Intentional child maltreatment viewed in relation to dysfunctions within the individual (caretaker or child)

8. Develop Generalizations V A, V B, V C Sample Content 5 for each, utilizing

   a) Circumstantial child maltreatment and the individual (caretaker or child) ability to cope with stress

   b) Incidental child maltreatment and the individual (caretaker or child) ability to cope with stress

   c) Intentional child maltreatment and the individual (caretaker or child) ability to cope with stress

9. Have students read student resources for Units I through IV and discuss each in relation to circumstantial, incidental, or intentional child maltreatment.

10. Students may:

   - Write a brief paragraph or paper recommending preventive measures for
     circumstantial
     incidental   child maltreatment resulting from dysfunctions
     intentional   within society
   - Write a brief paragraph or paper recommending preventive measures for
     circumstantial
     incidental   child maltreatment resulting from dysfunctions
     intentional   within the family
   - Write a brief paragraph recommending preventive measures for
     circumstantial
     incidental   child maltreatment resulting from dysfunctions
     intentional   within the caretaker or within the child
   - Write a brief paper relating The Criteria for Emotional Maturity (III.4) to circumstantial, incidental, and intentional child maltreatment

11. Conclude with assessment measures for Performance Objectives (A) 1-5; (B) 6-10; and (C) 11-15.

UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective Two

The student will be able to state the provisions of federal, state, and local child maltreatment law.

Performance Objectives for Generalization D

1. DESCRIBE briefly the chronology and extent of child maltreatment law in the U. S.
2. STATE the provisions of the federal Child Abuse Prevention and Treatment Act of 1974.
3. STATE the provisions of the state laws for a) abuse and b) neglect.
4. COMPARE the state law with the local law for a) abuse and b) neglect.
5. DESCRIBE in detail the local reporting process a) for abuse, b) for neglect.

Generalization D

CHILD MALTREATMENT -- WHETHER CIRCUMSTANTIAL, INCIDENTAL, OR INTENTIONAL -- IS DEFINED BY LAW.

Sample Content

1. Child maltreatment legislation
2. Current child maltreatment laws
    - a) State law
    - b) Local
3. The local process for reporting child abuse
    - a) Mandatory by law
    - b) Identity not required
    - c) Provision for immunity
    - d) Authorized agencies
    - e) Methods of investigation
    - f) Registration of case
        - 1) Local
        - 2) Central
4. The local process for reporting child neglect

Suggested Classroom Activities and Procedures for Performance Objectives

1 through 5

1. Prepare students through a review of Unit I Generalization B Sample Content 1 through 4. Include also Suggested Classroom Procedures and Activities for Performance Objectives.

   Utilize Transparencies 7 through 12 for discussion where appropriate.
2. Introduce Generalization V D, and write on board for students.
3. Clarify student understanding of terms through a brief review of Generalizations V A, V B, and V C.
4. Have students read and discuss in class:
   - a) "Child Abuse in the United States" (V.2)
   - b) "Child Abuse Legislation in the 1970's" (V.3)
   - c) "Child Abuse: Attempts to Solve the Problem by Reporting Laws" (V.4)
5. Develop student understanding of the federal Child Abuse Prevention and Treatment Act of 1974 (V.5).
6. Show and discuss Transparency 5 and Transparency 6.
7. Develop student understanding of the Maryland State child maltreatment laws (V.6 and V.7).
   - a) Child Abuse
     - 1) Physical injury
     - * 2) Sexual abuse
     - 3) Protection for children up to age 18
     - 4) Must be inflicted by a caretaker responsible for the child's welfare

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* See Appendix F.

b) Child Neglect

    1) Under age of 18

    2) "Child in need of assistance"

8. Develop student understanding of the Montgomery County child maltreatment law.

    a) Montgomery County abuse law is part of the Maryland State criminal code.

    b) Montgomery County neglect law is part of the Maryland State civil code.

    c) Montgomery County has adopted the State Department of Human Resources guidelines for neglect. (See "A Policy Statement on Child Abuse and Neglect" (VI.3)

9. Develop student understanding of the reporting process in terms of:

    a) The state reporting process (may differ in each locality) for abuse and for neglect

    b) The local reporting process for abuse and for neglect

10. Students may:

    - Invite a member of the local Child Protection Team to discuss the local reporting process
    - Group discuss the definition of emotional neglect (V.8)
    - Write a review of The Problem of the Battered Child (V.10)
    - Make a list of important steps in preparing a neglect proceeding (V.9)
    - Write a condensation of Child Abuse Syndrome: A Review (V.11)
    - View selected films on child maltreatment

11. Refer to student options for Performance Objectives 1 and 2 for II A.

12. Conclude with assessment measures for Performance Objectives 1 through 5.

EVALUATION

for

V. The Problem of Child Maltreatment

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1 THROUGH 3 -- UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One: The student will be able to identify the individual and societal problem of child maltreatment.

Generalization A Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 1. STATE the meaning of the term circumstantial child maltreatment.	Define the term circumstantial in relation to child maltreatment.	The student will give correct information by utilizing the resources listed below: V A Sample Content 1 V.1 Unit I Unit II
2. DESCRIBE circumstantial child maltreatment in relation to dysfunctions within society.	Give _____ examples of circumstantial child maltreatment resulting from dysfunctions within society.	V A Sample Content 2 V.1 Unit I Unit II
3. DESCRIBE circumstantial child maltreatment in relation to dysfunctions within the family.	Give _____ examples of circumstantial child maltreatment resulting from dysfunctions within the family.	V A Sample Content 3 V.1 Unit I Unit II

Key Word[1] (See Appendix A.)

STATE - to make a declarative word phrase setting forth something

DESCRIBE - to state a verbal picture or /to/list the characteristics of a person, place, thing, or event

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[1] Thomas Evaul, Behavioral Objectives, Their Rationale and Development (Merchantville, New Jersey: Curriculum and Evaluation Consultants) 1972.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1 THROUGH 3 --
UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One: The student will be able to identify the individual and societal problem of child maltreatment.

Generalization A Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
4. EXPLAIN the relationship of circumstantial child maltreatment to dysfunctions in the individual.	In a brief paragraph, explain the possible relationship of circumstantial child maltreatment to dysfunctions in the caretaker. In a brief paragraph, explain the possible relationship of circumstantial child maltreatment to dysfunctions in the child.	V A Sample Content 4 V.1 Unit I Unit II Unit III Unit IV
5. PREDICT the probability of circumstantial child maltreatment in relation to individual ability to cope with stress.	In a brief paragraph, explain the importance of the caretaker's ability to cope with stress relative to circumstantial child maltreatment. In a brief paragraph, explain the importance of the child's ability to cope with stress relative to circumstantial child maltreatment.	V A Sample Content 5 V.1 Unit I Unit II Unit III Unit IV

Key Word[2] (See Appendix A.)

EXPLAIN - to describe the relationship between things and/or /to/present the reasons for an occurrence or relationship

PREDICT - to state a possible conclusion before it occurs

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[2] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 6, 7, AND 8 --
UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One: The student will be able to identify the individual and societal problem of child maltreatment.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 6. STATE the meaning of the term incidental child maltreatment.	Define the term incidental in relation to child maltreatment.	The student will give correct information by utilizing the resources listed below: V B Sample Content 1 V.1 Unit I Unit II
7. DESCRIBE incidental child maltreatment in relation to dysfunctions within society.	Give _____ examples of incidental child maltreatment resulting from dysfunctions within society.	V B Sample Content 2 V.1 Unit I Unit II
8. DESCRIBE incidental child maltreatment in relation to dysfunctions within the family.	Give _____ examples of incidental child maltreatment resulting from dysfunctions within the family.	V B Sample Content 3 V.1 Unit I Unit II

Key Word[3] (See Appendix A.)

STATE - to make a declarative word phrase setting forth something

DESCRIBE - to state a verbal picture or /to/ list the characteristics of a person, place, thing, or event

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[3] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 9 AND 10 --
UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One: The student will be able to identify the individual and societal problem of child maltreatment.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
9. EXPLAIN the relationship of incidental child maltreatment to dysfunctions within the individual.	In a brief paragraph, explain the possible relationship of incidental child maltreatment to dysfunctions in the caretaker. In a brief paragraph, explain the possible relationship of incidental child maltreatment to dysfunctions in the child.	V B Sample Content 4 V.1 Unit I Unit II Unit III Unit IV
10. PREDICT the probability of incidental child maltreatment in relation to individual ability to cope with stress.	In a brief paragraph, explain the importance of the caretaker's ability to cope with stress relative to incidental child maltreatment. In a brief paragraph, explain the importance of the child's ability to cope with stress relative to incidental child maltreatment.	V B Sample Content 5 V.1 Unit I Unit II Unit III Unit IV

Key Word[4] (See Appendix A.)

EXPLAIN - to describe the relationship between things and/or /to_/present the reasons for an occurrence or relationship

PREDICT - to state a possible conclusion before it occurs

[4] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 11, 12, AND 13 -- UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One: The student will be able to identify the individual and societal problem of child maltreatment.

Generalization C Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
11. STATE the meaning of the term intentional child maltreatment.	Define the term intentional in relation to child maltreatment.	V C Sample Content 1 V.1 Unit I Unit II
12. DESCRIBE intentional child maltreatment in relation to dysfunctions within society.	Give _____ examples of intentional child maltreatment resulting from dysfunctions of society.	V C Sample Content 2 V.1 Unit I Unit II
13. DESCRIBE intentional child maltreatment in relation to dysfunctions within the family.	Give _____ examples of intentional child maltreatment resulting from dysfunctions of the family.	V C Sample Content 3 V.1 Unit I Unit II

Key Word[5] (See Appendix A.)
STATE - to make a declarative word phrase setting forth something
DESCRIBE - to state a verbal picture or /to/ list the characteristics of a person, place, thing, or event

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[5] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 14 AND 15 --
UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One: The student will be able to identify the individual and societal problem of child maltreatment.

Generalization C Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
14. EXPLAIN the relationship of intentional child maltreatment to dysfunctions within the individual.	In a brief paragraph, explain the possible relationship of intentional child maltreatment to dysfunctions in the caretaker. In a brief paragraph, explain the possible relationship of intentional child maltreatment to dysfunctions in the child.	V C Sample Content 4 V.1 Unit I Unit II Unit III Unit IV
15. PREDICT the probability of intentional child maltreatment in relation to individual ability to cope with stress.	In a brief paragraph, explain the importance of the caretaker's ability to cope with stress relative to intentional child maltreatment. In a brief paragraph, explain the importance of the child's ability to cope with stress relative to intentional child maltreatment.	V C Sample Content 5 V.1 Unit I Unit II Unit III Unit IV

Key Word[6] (See Appendix A.)

EXPLAIN - to describe the relationship between things and/or /to /present the reasons for an occurrence or relationship

PREDICT - to state a possible conclusion before it occurs

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[6] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1, 2, AND 3 -- UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective Two: The student will be able to state the provisions of federal, state, and local child maltreatment law.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 1. DESCRIBE briefly the chronology and extent of child abuse and neglect law in the U.S.	In a brief paragraph, describe the chronology and extent of child abuse and neglect law in the U.S.	The student will give correct information by utilizing the resources listed below: V B Sample Content 1 V.2 V.8 V.3 V.9 V.4 V.10 V.11 Transparencies 7 - 12
2. STATE the provisions of the federal Child Abuse Prevention and Treatment Act of 1974.	In outline form, state the provisions of the federal Child Abuse Prevention and Treatment Act of 1974.	V B Sample Content 1 V.5 V.10 V.8 V.11 V.9 Transparency 5 Transparency 6
3. STATE the provisions of the state law for a) abuse b) neglect	In outline form, state the provisions of the state law for a) abuse b) neglect	V B Sample Content 2 V.6 V.9 V.7 V.10 V.8 V.11 Transparencies 7 - 12

Key Word[7] (See Appendix A.)

DESCRIBE - to state a verbal picture or /to/ list the characteristics of a person, place, thing, or event

STATE - to make a declarative word phrase setting forth something

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[7] Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 4 AND 5 --
UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective Two: The student will be able to state the provisions of federal, state, and local child maltreatment law.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will:		The student will give correct information by utilizing the resources listed below:
4. COMPARE the state law with the local (Montgomery County) law for a) abuse b) neglect	In outline form, compare the state law with the local (Montgomery County) law for a) abuse b) neglect	V B Sample Content 2 V.1 V.9 V.6 V.10 V.7 V.11 V.8 Transparencies 7 - 12
5. DESCRIBE in detail the local reporting process for a) abuse b) neglect	In outline form, describe in detail the local reporting process for a) abuse b) neglect	V B Sample Content 3 and 4 V.1 V.9 V.6 V.10 V.7 V.11 V.8 VI.3 Transparencies 7 - 12

Key Word[8] (See Appendix A.)

COMPARE - to list the similarities and differences of things

DESCRIBE - to state a verbal picture or /to/ list the characteristics of a person, place, thing, or event

[8] Evaul.

CLASS RECORD FORM

S = SATISFACTORY

UNIT V: THE PROBLEM OF CHILD MALTREATMENT

U = UNSATISFACTORY

CLASS ______________________________ PERIOD ________________

INSTRUCTIONAL OBJECTIVE ONE: The student will be able to identify the individual and societal problem of child maltreatment.

	PERFORMANCE OBJECTIVE															AVERAGE %	
NAME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	S	U
AVERAGE % S																	
U																	

CLASS AVERAGE

GRADE KEY

S----SATISFACTORY for PERFORMANCE OBJECTIVES

U----UNSATISFACTORY for PERFORMANCE OBJECTIVES

60% SATISFACTORY = CREDIT for COURSE

STUDENT ______________________

FINAL GRADE

TOTAL % SATISFACTORY for COURSE ______

TOTAL % UNSATISFACTORY for COURSE ______

INDIVIDUAL STUDENT RECORD

	PERFORMANCE OBJECTIVES																	AVERAGE % Instructional Objectives	
																		S	U
UNIT I Instructional Objective	1	2	3	4	5	6	7	8											
UNIT II Instructional Objective	1	2	3	4	5	6	7	8	9	10									
UNIT III Instructional Objective	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
UNIT IV Instructional Objective	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17		
UNIT V Instructional Objective One	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
UNIT V Instructional Objective Two	1	2	3	4	5														
UNIT VI Instructional Objective One	1	2	3	4															
UNIT VI Instructional Objective Two	1	2																	

CLASSROOM INSTRUCTIONAL MATERIALS

for

V. The Problem of Child Maltreatment

1. Definition of Terms (V.1)
2. "Child Abuse in the United States" (V.2)
3. "Child Abuse Legislation in the 1970's" (V.3)
4. "Child Abuse: Attempts to Solve the Problem by Reporting Laws" (V.4)
5. "The Child Abuse Prevention and Treatment Act of 1974"(V.5)
6. Child Abuse: Maryland State Child Maltreatment Law (V.6)
7. Child Neglect: Maryland State Child Maltreatment Law (V.7)
8. "Defining Emotional Neglect" (V.8)
9. "Preparing for a Neglect Proceeding: A Guide for the Social Worker" (V.9)
10. "The Problem of the Battered Child" (V.10)
11. "Child Abuse Syndrome: A Review" (V.11)
12. Instructional Materials for Units I, II, III, and IV
13. Classroom learning center for child maltreatment

*DEFINITION OF TERMS (V.1)

Circumstantial	adj.	- 1: belonging to, consisting in, or dependent upon circumstances
Incidental	adj.	- occurring merely by chance or without intention or calculation
Intentional	adj.	- 1: done by intention or design

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* Webster's New Collegiate Dictionary, 1974.

(Exerpt from CHILD ABUSE by Jean Yavis Jones, Education and Public Welfare Division, Congressional Research Service, Library of Congress 75-97-ED)

I. CHILD ABUSE IN THE UNITED STATES

Ironically, it may very well be the abhorrence of child abuse which has made it such a slow-moving area of both Federal and State legislation. The very idea that a parent, who is supposed to love and protect his offspring, could be responsible for his or her child's physical injury, or even death, is so repulsive that many are reluctant to believe it. Our courts and legislatures have also been reluctant to get involved in internal family government, preferring to let the families determine their own laws and punishments. The implied "hands-off" policy followed by the government owes much to our close association with English Common Law. Under this Common Law, the right of the father to custody and control of his children was considered virtually absolute, even where this was at odds with the welfare of the child. This has carried over to some extent in our own legal system.

Early History of Child Abuse in the U.S.

In colonial America, the father ruled both his wife and his children. Parental discipline was severe, and parents, teachers and ministers found justification for stern disciplinary measures in the Bible.

Legally speaking, the early American child was, in fact, little more than the property of his parents. It was not unusual for a child to be bound out to other households as an indentured servant or apprentice. The shortage of labor in colonial America, as well as the strongly pervasive Puritan work ethic, was reflected in early laws. In 1642 a Massachusetts statute required parents and masters to provide for the "calling and imployment [sic] of their children."[1]

Early laws made a distinction between apprenticeship and servitude (the former requiring training in a trade) but this was not always followed. Eventually, two forms of apprenticeship evolved. Under a voluntary apprenticeship, the child and his parents entered into an agreement on their own initiative. The other form, compulsory apprenticeship, resulted from the practice of binding out dependent children, who had little or no say in the choice of their master or trade. As time went on laws were passed prohibiting the binding out of infants, but the practice of binding out children beyond infancy continued.

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[1] Order of the General Court of Massachusetts, 1642, Massachusetts Records, II (1853): 8-10.

The earliest recorded trial case of child abuse involved a master and his apprentice.[2] In Salem, Massachusetts, in 1639, a man by the name of Marmaduke Perry was arraigned for the death of his apprentice. The evidence given stated that the boy had been ill-treated and subject to "unreasonable correction" by his master. However, the boy's own charge that his master had been responsible for the fracture of his skull (which ultimately resulted in his death) was called to question by testimony that he had told someone else that the injury was the result of falling from a tree. The defendant was acquitted.

In 1643, a master was executed for causing the death of his servant boy,[3] and in 1655 in Plymouth a master was tried and "was subsequently found guilty of manslaughter and ordered 'burned in the hand' and all his goods confiscated."[4] Other early recorded cases show the masters of servant children being admonished for abuse and in some cases the children being freed from indenture because of ill-treatment. In 1700, Virginia issued specific laws for the protection of servants against mistreatment.

As can be seen, most of the early recorded cases of child abuse were specifically related to offenses committed by masters upon servants and did not reflect any movement toward protecting children from abusive treatment by their own parents.

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[2] Winthrop, John. The History of New England from 1630-1649. J. Savage, ed. Boston, v. 1, 1853: 318-319.

[3] Rev. John Eliot's Records of the First Church in Roxbury, Massachusetts. Sixth Report of Boston Record Commissioners, Boston, 1881: 187.

[4] Children and Youth in America: a Documentary History 1600-1865. R. Bremner, ed. Cambridge, Massachusetts, Harvard University Press, v. 1, 1970: 123.

Whatever court action there was involving family matters was limited to the removal of children from "unsuitable" home environments. "Unsuitable" usually referred to the parents not providing their children with a good religious upbringing, or refusing to instill in them the value of the work ethic. There were two cases in Massachusetts in 1675 and 1678 in which children were removed because of "unsuitable" homes."[5] In the first case, the children were removed because the father refused to see that they were "put forth to service as the law directs."[6] The second case gave similar justification for the removal of the children, with that offense being compounded by the refusal of the father to attend church services.

The removal of children from such "unsuitable" home environments did not reflect any concern about the physical abuse of children and, in fact, may have been responsible for putting them into a more potentially dangerous environment. It was a common practice for children who were dependent upon public support to be bound out. These children would be auctioned off to the lowest bidder, who would then accept his payment from public funds and take the child as a servant or apprentice.

In the larger cities where the problem of poverty was greater, dependent children were put into almshouses. Conditions in these public poorhouses were bad enough for adult paupers, let alone young children. It was not until the beginning of the nineteenth century that major efforts were made to provide separate residences for children, and it was not until then that public recognition of the abuse of these children in institutions was noted.

The dearth of recorded family child abuse cases in early American history suggests the general tendency of the courts to allow parents their own discretion in determining the kind and degree of home discipline. Parents were considered immune from prosecution unless the punishment was beyond the bound of "reasonableness" in relation to the offense, or excessive, or the child injured permanently.[7]

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[5] Ibid, p. 41-42.
[6] Ibid, p. 41.

In 1840, there was a criminal case in Tennessee which involved parental prosecution for excessive punishment. "The evidence showed that the mother struck the child with her fists, and had pushed her head against a wall and that the parents had whipped her with a cowskin, tied her to a bedpost with a rope for two hours, and switched her. The court reversed the parents conviction holding that whether punishment was excessive was a question of fact for the jury to decide rather than a question of law."[8]

Early Reform Movements -- Children as Animals

It was not until the second decade of the nineteenth century that public authorities began to intervene in cases of parental neglect. Most of the reform movements were directed toward children in institutions, however, and were aimed at preventing a neglected child from entering a life of crime.

Probably the most significant and helpful of all reform campaigns for child protection was that launched by the American Society for the Prevention of Cruelty to Animals (ASPCA). In 1874, a church worker sought the help of the President of the ASPCA on behalf of an abused child. The case concerned a ten-year-old foster child named Mary Ellen Wilson who was the victim of child abuse. At that time there were laws which protected animals but no local, State or Federal laws to protect children. The case was presented to the court on the theory that the child was a member of the animal kingdom, and therefore entitled to the same protection which the law gave to animals.[9]

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[7] Thomas. Mason P. Child Abuse and Neglect. Part I: Historical Overview, Legal Matrix and Social Perspectives. North Carolina Law Review, v. 50: 305.

[8] Ibid. p. 305.

[9] New York Times, April 10, 11, 1874, and December 27, 1875.

In the aftermath of public indignation over the case, Elbridge T. Gerry, the lawyer who represented the ASCPA, founded the New York Society for the Prevention of Cruelty to Children. It was originally organized as a private group and later incorporated. Legislation was soon passed in New York and cruelty societies were authorized to file complaints for the violation of any laws relating to children, and law enforcement and court officials were required to aid the societies.

Similar societies were soon organized in other cities throughout the country and by 1922 there were 57 Societies for the Prevention of Cruelty to Children, and 307 humane societies concerned with the welfare of children. With the advent of government intervention into child welfare the number of these societies has declined.

Recent Developments

One of the main reasons for the lack of prosecution in child abuse cases has always been the difficulty in determining whether the physical injury was, in fact, a case of deliberate assault or an accident. In recent years, however, doctors in the area of pediatric radiology have been able to determine the incidence of repeated child abuse through more sophisticated developments in x-ray technology. These advances have allowed radiologists to see more clearly such things as subdural hematomas (blood clots around the brain resulting from blows to the head) and abnormal fractures. This has brought about more recognition of the widespread incidence of child abuse and public reaction has been on the rise.

State Legislation

The discovery of the bruised and weighted down body of three-year old Roxanne Felumero in the East River in 1969 set off particular furor when it was discovered that just two months prior to her death her parents had been brought before the New

York Family Court for alleged neglect and abuse, and the judge had released the child back to their custody. The inability of the courts to conclusively prove the criminal act of child abuse can lead to just this kind of tragic situation.

The problem of protecting a child from abuse is a particularly difficult one, for it involves a victim who often will not, or cannot testify against his or her attacker; it is usually committed in the privacy of the home, and even when it is reported.it is difficult to prove in the absence of eyewitnesses.

All fifty States have some form of child abuse laws. These are basically concerned with reporting laws which encourage or require the reporting of suspected child abuse (usually by doctors and other professional persons); criminal law provisions to punish those who abuse children; juvenile court acts, and State legislation to establish or authorize protective services for children.

Between 1963 and 1969, all fifty State legislatures passed some kind of child abuse reporting statute, and all but four had mandatory requirements for reporting. (See Part III-B --The Laws for Reporting Child Abuse.) It is estimated that there are thousands of cases of child abuse which remain unreported every year. The problem is difficult to solve through legislation. The reluctance of people to get involved, and the possibility of civil suits against them if they do, seems to remain a deterrent, despite the fact that all but one of the States have passed some form of immunity legislation. Part of the problem may also lie in the lack of information about the subject. The first studies which appeared in the early 1960's were often more sensational than informative. Since that time more substantive studies have been conducted.

The degree of immunity given and laws making the reporting of child abuse mandatory vary from State to State. In many States there are penal sanctions for failure to report. Most of these involve financial penalties, but there are a few States which have criminal penalties. Because of the variance of reporting laws, legislative models have recently been proposed by such groups as the United States Children's Bureau, the Council of State Governments, the American Humane Association and the American Medical Association.

Federal Legislation

The Federal Government did not get involved in child welfare until 1912, when after considerable debate, Congress passed a bill to create the United States Children's Bureau. This bill was signed into law by President Taft on April 9, 1912, and authorized the creation of a special bureau to do research and provide information about children. In 1935, with the passage of the Social Security Act, the Federal Government became more directly involved in child welfare services. The grants were to be used for "...the protection and care of homeless, dependent and neglected children and children in danger of becoming delinquent." (Now Title IV-B)

The 1962 Social Security Amendments required each State to make child welfare services available throughout the State to all children and provide coordination between current child welfare services (Title IV-B) and the social services under the Aid to Famililies With Dependent Children (IV-A) program. This latter requirement was to be accomplished by making maximum use of child welfare staff in providing consultation and services for children in families receiving public assistance. The 1962 amendment also revised the definition of "child welfare services" to specifically include reference to the prevention or remedying of child abuse.10/

Since 1962, most of the funds for services for child protection have been spent under Title IV-A (new Title XX, effective October 1, 1975) which provides services primarily for families on welfare, with the major portion of funds under

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10/ U.S. Congress. Senate. Committee on Finance. Report on H.R. 10606 - Public Welfare Amendments of 1962. 87th Congress, 2nd Session, Washington, D.C., U.S. Govt. Print. Off., 1962: 15.

Child Welfare Services (Title VI-B) being spent on foster care. For example, of fiscal year 1972 Federal and non-Federal expenditures, it is estimated that $99.4 million was spent under Title IV-A Social Services Program for child protection services, as compared to $8.4 million for child protection services under Title IV-B.[11] Under Title IV-B Federal funding has been fixed by appropriations acts at between $46-$50 million each of the last several years, whereas under Title IV-A there is 75% Federal matching and, up until 1973, there was completely open-ended funding. (With the enactment of P.L. 92-512 a $2.5 billion limit was placed on Federal funding of Social Services.)

Services for child protection (under Title IV-A & B) end as soon as the child is removed from the home, but may be continued indirectly through foster care services for children removed from a home because of abusive treatement.

Funds have also been granted under Title V (Maternal and Child Health) for research studies on the subject of child abuse and neglect.

Thus, Federal legislative activity in the area of child abuse (with the exception of legislation for the District of Columbia) has been concentrated on financial assistance to the States for child welfare and social services and in research grants. Traditionally, the Federal government has stayed away from specific legislation regarding child abuse, considering it under the jurisdiction of the States. In the last few years, however, perhaps because of increasing awareness of the incidence of child abuse, and the resulting public outcry, a number of bills were introduced in Congress concerning mandatory reporting requirements and the creation of a National Center on Child Abuse and Neglect.

On January 31, 1974, one of these bills (S. 1191), entitled The Child Abuse Prevention and Treatment Act was enacted (P.L. 93-247).

11/ U.S. Congress. Senate. Committee on Finance. Staff Data and Materials on Social Service Regulations. 93rd Congress, 1st Session, Washington, D.C., U.S. Govt. Print. Off., 1973: Table A.

CHILD ABUSE LEGISLATION
IN THE 1970's

Revised Edition

By
Vincent De Francis, J.D.
and
Carroll L. Lucht, J.D.

The American Humane Association, Children's Division
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CHILD ABUSE LEGISLATION IN THE 1970's

SECTION I

THE LAWS FOR REPORTING CHILD ABUSE

Few recent social causes have aroused public sensibility, or created as much concern, as has our present awareness that child abuse is a shocking reality and a problem which knows no bounds in relation to economic or educational levels of parents.

While the current wave of public concern is of comparatively recent origin, the problem itself is old to protective service workers. The first recorded child protective case – The Mary Ellen Case, New York City, 1874 – involved a grossly abused child whose plight became a "cause celebre" when laws to protect animals had to be invoked in her behalf because no laws to protect children had as yet been enacted.

Public indignation at parental disregard of the rights of children and for their traditional protective role is frequently turned toward punitive action against parents who transgress ideals about family responsibility for children. All too frequently, however, the need for constructive planning and the need for services on behalf of the abused child are given only secondary consideration because of the hostility engendered in the process of pursuing sanctions against offending parents.

SIZE OF THE PROBLEM

There are no accurate national statistics on the incidence of child abuse. Several studies serve to index the size of the problem.

Of particular significance is a 1962 study by the Children's Division of The American Humane Association. That study reviewed cases of child abuse reported in United States newspapers. The study amassed information on 662 incidents culled from newspapers in 48 states. The cases represented the grossest types of child abuse – situations which were reported to law enforcement authorities and which were deemed "newsworthy" by the local press. The severity of abuse reported may be judged from the fact that in 178 of the cases, almost one-fourth of the total, the child died from the injuries.

The 662 cases studied represent only that portion of child abuse incidence which was identified and reported by the press. For each such case making the headlines there may well be a hundred or more, unseen, unreported and unidentified.

Educated estimates place the probable national incidence of *serious* child abuse at more than 10,000 cases a year. There are, no doubt, many additional thousands of cases in which the mistreatment is of less dangerous proportions. David Gil's nationwide study at Brandeis University produced a finding of 9,300 cases of reported child abuse for the nation in 1967 with "approximately 6,000 cases of confirmed abuse." Cases were reported to that study by central registries in the states and territories.

The Children's Division of The American Humane Association, through a grant from the United States Children's Bureau and the Office of Child Development, is in the initial stages of establishing a national information center on child abuse and neglect. It will serve as a national clearinghouse to collect information on abuse and neglect on a systematic, on-going basis. It is hoped that through the operation of the center the magnitude of the abuse problem in the United States can be more accurately documented. The Clearinghouse should be operational early in 1974.

But even with a means of obtaining an accurate count of reported child abuse cases, the essential question remains: How to find and identify the vast number of child abuse cases which are hidden from public view and thus not reported. Not only did this question pose the problem which promoted the move for mandatory reporting statutes, but it continues to be the principal subject of amendatory legislation.

WHY A REPORTING LAW?

The need to discover and identify child victims of abuse is the compelling reason for devising a casefinding tool such as the reporting law. Medical personnel came to be selected as the principal target group of the law's mandate as a result of ferment within medical circles where research and study was producing irrefutable evidence that some cases of child abuse can be determined by medical diagnosis.

Numerous articles in medical journals implore practitioners to exercise great care when examining children brought to them for treatment of injuries. All too frequently, they are told, doctors accept glib stories about such injuries resulting from accidental cause. The use of X-rays and a study of all symptoms may reveal findings inconsistent with the history given, and may provide the doctor with reasonable cause to suspect inflicted, rather than accidental, injury. Failure to recognize the "Battered Child Syndrome" could subject the child to additional or repeated injury or even death.

The logic and force of medical concern as expressed in the literature has focused attention on the doctor as the probable first responsible contact with child victims of abuse. Doctors may be the first "outsiders" with opportunity to see and examine the child, and the first competent persons capable of assuming responsibility for positive action on behalf of the child. Thus, they are seen as the best resource for early identification and reporting of such cases as are brought to them for treatment.

But are doctors willing to voice their suspicions by reporting these cases when the diagnosis of inflicted injuries is not clear cut – particularly in the face of a denial by the parents? Would such reporting expose doctors to the possibility of a legal action for money damages? Would doctors feel that such reporting runs counter to ethical considerations in regard to privileged communication between doctor and patient?

To overcome these blocks to free reporting, legislation has been enacted making reporting of child abuse mandatory and providing immunity from legal action to persons making a report. These laws also include a waiver of the doctor-patient privilege. Waiver of the husband-wife privilege frees a spouse to testify about abuse committed by the other spouse.

Procedural matters regarding the manner and method of reporting are dealt with. An immediate oral report by telephone to be followed by a written report is commonly required. Also included are requirements covering content, i.e., age of the child, names, addresses, etc.

PHILOSOPHY AND PURPOSE OF REPORTING LAWS

The most important consideration in the concept of mandatory reporting is a statement of the purpose to be served by the report. Obviously, the core objective is early identification of children who have been physically abused, so that they can be (1) treated for present injuries and (2) protected from further abuse.

Achieving the first prong of this objective–treating children's injuries–presents no serious problem except in cases where parents, for religious or other scruples, may refuse permission for needed medical care. Depending on the specifics of each such case, that problem can be dealt with by invoking the authority of the juvenile court to order necessary medical care over parental objections.

The second part of the objective is one where different approaches may be, and are being, used. Here we are looking at the pattern a community creates for treating the situation so as to protect the child from further injury. Consideration of this point requires that we examine what process the community employs to prevent additional abuse.

THE EMOTIONAL CLIMATE OFTEN SUPPORTS PROSECUTION

As noted earlier, the general attitude toward the problem of child abuse, and a common reaction of people when confronted with the brutal facts, is shock and anger. A natural consequence is the desire to exact retribution–to punish unnatural parents for their acts of cruelty.

Where that philosophy prevails, reporting legislation is viewed as a tool for identifying parents who mistreat children so that society may deal with them for the crime of child abuse.

What are the merits of this approach? On the positive side, we can say that justice, in the strict legal sense, is sought to be served. The negatives, however, are many.

Criminal prosecution requires proof through evidence which establishes the culpability of a parent beyond a reasonable doubt. Because these acts usually take place in the privacy of the home, without outside witnesses, and because parents, with rare exception, are mutually protective in these cases, lack of evidence makes it impossible to identify which parent was the offender, or to sustain the legal burden of proof. An unsuccessful prosecution may subject the child victim to increased hazards for he will be exposed to the care of a parent who, in addition to his other problems, may now be embittered by his experience with police and court. A disturbed parent may view the prosecution's failure to find him guilty of child abuse as a license to continue to abuse.

Other factors mitigate against viewing mandatory reporting as a means for identifying and prosecuting offending parents. If seeking medical attention for the injured child may expose a parent to the possibility of criminal prosecution, fear of the consequences may prevent taking a child for medical help until the situation becomes acute–or, perhaps, until too late to help the child. Of equal weight is the concern of doctors who may resist reporting cases if by so doing they become involved as witnesses in a criminal proceeding against the parents. Because doctors identify with the "helping" ethic, they would find repugnant anything which places them in a punitive role. The net result could be a stalemate–and a defeat of the law's objective to encourage reporting and early casefinding.

An additional consideration is the fact that punishment of abusing parents through criminal prosecution does not correct the fundamental cause of their behavior. If we recognize the mental, physical and emotional inadequacies of these people then we must recognize that prosecution and punishment will not produce true change in their behavior. At best it can only produce surface compliance, with deeper motivational forces remaining untreated and the emotional damage to their personality becoming greater as a result of the punitive experience.

This is not to say that parents should never be prosecuted for child abuse. Certainly, the community has a duty to act against parents who commit heinous criminal acts against children. Where a felony has been committed this duty cannot be evaded. But the decision of whether or not to prosecute in a given case should rest with the county prosecutor. In making this decision he must also consider what happens to children. No decision to prosecute parents can afford to overlook the necessity for adequate planning for the abused child and other children in the family.

SOCIAL PLANNING FOR CHILDREN MEETS THEIR NEEDS BEST

The second approach is rooted in a philosophy which sees the purpose of casefinding to be the discovery of children who, because of abuse, need the care and protection of the community. The community carries out this responsibility by making available the protective social services which will (1) prevent further abuse of the child and (2) meet the child's needs through social services and social planning to assure maximum protection.

This approach is served best if the reporting, at the outset, is directed to the child protective program in the community. Such services are usually found in the public child welfare agency.

Child protective programs are especially qualified to "reach out" to families where children are neglected or abused. Their functional responsibility requires that they:

(1) explore and determine the facts of neglect or abuse,
(2) assess and evaluate the damage to children,
(3) initiate appropriate social work services to remedy the situation, and,
(4) invoke the authority of the juvenile court in those situations where removal from parental custody must be sought in the best interests of children.

The "helping-through-social-services" philosophy is stretched to include the parents. This is based on the recognition that destructive parental behavior is symptomatic of deeper emotional problems. Rarely is child abuse the product of wanton, willful or deliberate acts of cruelty. It results from emotional immaturity and from lack of capacity for coping with the pressures and tensions of modern living. Parents who abuse children are frequently people with personality defects or character disorders. They may be neurotic, emotionally disturbed or mentally ill. The symptoms of their disorganized state are manifested in deviant behavior and bursts of violence or anger directed at other people, including their children.

Many of these parents may themselves have been victims of parental neglect or abuse, and their behavior is a reflection of what they were exposed to as children. Most of them are not capable of providing adequate care for their children without outside help.

What such parents need is help – help and treatment. They need services to guide and counsel them toward accepting their responsibilities as parents – to rebuild their damaged personalities – to give them the strength and stability to successfully live up to parental roles.

But while many parents will respond to skilled services, some parents cannot be helped. Others cannot be helped soon enough to avoid the risk of exposing their children to more abuse. In such cases the protective social service will take action through the juvenile court to remove the child from a dangerous situation. The best interest of the child – his very safety – may dictate removal from the home as an immediate and necessary action. Decisions of this type require mature, experienced judgment, plus skill and training in handling children's problems.

With these philosophical considerations as a background let us examine the legislation enacted to implement them.

LEGISLATIVE ACTION

The grim reality of child abuse and the shocking revelations of research in this area spurred communities into social action. Public concern and recognition of need pressured legislative bodies into giving attention to the problem at a pace with little precedent in recent legislative history.

In the span of four legislative years all 50 states enacted laws seeking reports of injuries inflicted on children. The rush to go on record on behalf of child victims of abuse began with the introduction of 18 bills in 1963. Of that number, 11 achieved passage that year. These were the first such laws anywhere.[*]

The tempo continued in 1964, a legislative off-year, with 10 additional states passing similar laws. The momentum reached full pitch in 1965 when 26 states were added to the roster of states with reporting laws. Five states – California, Minnesota, Ohio, Oregon and Tennessee – began a second go-round with the 1965 sessions of their legislatures, passing amendments to reporting laws enacted in 1963 or 1964.

Some of the laws achieving passage in the 4-year period were hastily conceived and reflect public indignation against parents who abuse children. Most of them, however, were more thoughtfully prepared. They show awareness of the imperative need for protective social services on behalf of child victims if they are to be truly protected.

The laws are characterized by many differences in form and substance. Some of the differences are minor and may be attributed to the differing administrative or organizational structure in each state. Other differences are more generic and reflect a variance in the philosophy of how to treat the problem of child abuse. This is particularly true in relation to the approaches discussed above.

The laws also contain many areas of common agreement and areas of conformity with suggested legislation and guidelines developed by national agencies promoting mandatory reporting laws.

The degree of conformity, the extent of common agreement, the stated or implied philosophy and the strengths and weaknesses of the 53 enactments (50 states, 3 territories) are reviewed and assessed in the analysis which follows.

STATUS OF REPORTING LEGISLATION

In the sections which follow we have reflected recent changes in the reporting laws of the 50 states. As reported earlier, although these laws are a rather new development, individual state legislatures have developed a passion for tinkering with them. Each legislative session has seen a rash of bills introduced on the subject of child abuse. Most are consigned to the wasteland of bills which fail of passage. Some make the successful transition into law. Eighteen states and the Virgin Islands modified their reporting laws between 1967 and 1970 when the first edition of *Child Abuse Legislation in the 1970's* was published. In the ensuing three years a total of 37 states enacted substantive amendments – 17 of those coming during the 1973 legislative sessions.

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[*] California was reputed to have an earlier law, but it did not specifically relate to children. The old law required reporting of any injuries inflicted by any person in violation of any Penal law. California enacted its first child abuse reporting law in 1963 and amended it in 1965, 1968, 1971, 1972, and 1973.

Reporting laws are digested and cited in relation to 14 basic elements. To permit full understanding of the laws and the analytical discussion, these elements are defined below.

1. Statement of Purpose

State policy in regard to the subject matter of a specific law is often found in a purpose clause which defines the intent sought to be served by a particular legislative act. In that statement, the legislature goes on record with an expression of the ultimate goals and objectives which it seeks to achieve by the law. If there be ambiguities in the legislative language the purpose clause serves as a guide for interpreting or resolving doubts created by other language.

Review of the 53 laws reveals that 34 states, the District of Columbia, and the Virgin Islands have incorporated a purpose clause in their reporting laws. Thus, 65% of the jurisdictions recognize the strengths which accrue to the law when it contains a statement of purpose and objectives.

After defining the primary goal the legislators elaborate on the statement of purpose by defining the mechanism which they intend to set in motion in response to a report of child abuse.

So, to the primary goal is added language which broadens its scope and application — language which, at the same time, identifies legislative intent in regard to the kind of community resources sought to be marshaled into action on behalf of abused children reported under this act.

2. Age Limits for Reportable Children

There is considerable variation in the upper age limit employed by the states in defining the age of the child coming within the protection of the reporting law. Twenty six states, the District of Columbia and Guam have set the upper age limit at 18, five states use the age of 17 and eight states have established 16 as the upper age limit. Oregon and the Virgin Islands restrict the protection of the reporting law to children who have not yet attained the age of 15. The California law specifies the age of 12 as the upper limit. Nine states have reporting statutes which do not specify the age of protected children. In lieu of a stated age they employ the terms "child" and "minor," thereby making it necessary to refer to other parts of the statutes in order to determine the age limits.

Two states, Delaware and Washington, have extended coverage of the reporting law to include the mentally retarded, irrespective of age. Nebraska requires a report involving abuse of any "incompetent or disabled person," and Ohio provides protection to "any crippled or otherwise physically or mentally handicapped child under 21 years of age."

Age limits based on juvenile court jurisdictions seem most logical because the court is a resource whose services may have to be invoked on behalf of the child by the protective social services in circumstances of acute risk and hazard.

3. What is Reportable

This is the second important jurisdictional element required to bring a situation within the scope of the law. For a specific case to be reportable the reporting person must have "reason to believe"; "reasonable cause to suspect"; or "have reasonable or just cause to believe" that a child's injuries were inflicted by other than accidental means; or as a result of abuse or neglect. While some of the statutes contain somewhat different language, their meaning is substantially the same.

The effect of this language is that the reporter's diagnosis need not be absolute. He does not have to prove conclusively, even to himself, that the child is a victim of inflicted injury. If the circumstances are such as to cause him to feel doubt about the history given; if he has cause to doubt the truthfulness of the person who tells him about the alleged accidental cause of the injury; or if X-ray or other examinations reveal symptoms and facts inconsistent with the circumstances described, then he has sufficient "reasonable cause to suspect" that the injuries may have been inflicted rather than accidental. This would be enough to satisfy the requirements of the law.

4. Definition of Abuse

Eighteen states have attempted to enlarge upon "reportable conditions" by including a definition of abuse in their reporting laws. The degree of specificity contained in the definitions varies greatly from jurisdiction to jurisdiction. The Colorado, Idaho and Wyoming statutes define abuse in very explicit, medically symptomatic terms. On the other hand, Alaska defines abuse very broadly as "the infliction, by other than accidental means, of physical harm upon the body of a child." Other states, such as Nebraska, also use a broad definition but enumerate specific abusive acts, e.g., leaving a child ". . . unattended in a motor vehicle, if such minor child is six years of age or younger."

Statutes also differ significantly in that some definitions contain elements of intent. The Oregon definition, for example, requires that the injury be *"intentionally or wantonly"* inflicted. Maryland's definition demands that in order to constitute abuse, the injury must be sustained as a result of "cruel or inhumane treatment or as a result of malicious act or acts. . . ."

5. Nature of Report

Reporting legislation is a device for compelling or inducing persons with knowledge of suspected child abuse to report the facts to the agency designated by the law. Consensus favors the concept of mandatory legislation. Logic for this rests on the knowledge that we tend to do that which we must. We are more prone to live up to a responsibility which cannot be evaded. The duty which permits no choice is a duty with which we comply more regularly.

In 1970 when the first study was published, four states had reporting laws which were permissive in nature. The person or persons cited in the law were under no legal obligation to report. Currently, however, in all 50 states, the District of Columbia, Guam and the Virgin Islands the reporting laws are mandatory. Those persons enumerated in the law *must report* all situations where they know or suspect that a child has been abused.

Six states (Arkansas, Hawaii, Iowa, New York, Maryland, South Dakota) have included provisions in their statutes which make reporting permissive for persons other than the target professionals enumerated in the mandatory reporting provision. Typical of such language is that contained in the Hawaii law which provides that "any other person who has reason to believe that a minor has had injury inflicted upon him as a result of abuse or neglect *may* report the matter."

Accusatory or Non-accusatory

Twelve states and the Virgin Islands have a clause in their reporting law which requires the reporting source to identify the perpetrator as falling within a class of persons "responsible for care of the child." This requirement arises from phrasing which says in effect that the child sustained injuries inflicted "by a parent or caretaker"; "by a parent, guardian or custodian"; or "by a parent, stepparent, legal guardian, or any other person having custody." Language such as this makes the reporter responsible for identifying the perpetrator of the inflicted injuries as one of the mentioned caretakers.

Should the maker of the report be obliged to identify who injured the child? Does not this requirement constitute a serious block to reporting?

Meeting this obligation places the reporter in an accusatory role. Where the reporting law is housed in the criminal code (in 14 states and the Virgin Islands) the person reporting is in effect asked to make allegations of criminal activity. And where reportable abuse includes only those injuries inflicted intentionally or willfully (in seven states), the reporter is required to make a determination of intent. It is far less demanding upon the reporting source to report only cases where the circumstances are suspicious without the necessity for identifying either *intent* or the *perpetrator*.

6. Who Reports

All but six states designate the medical profession as the principal target group for reporting legislation. Medical practitioners constitute the most logical and responsible group to come in contact with children whose injuries require treatment. They are also the most competent to make the diagnosis of "injury probably due to other than accidental cause."

Many states include other professionals in the group of those who are obliged to report. Thus, teachers, social workers, visiting nurses, school administrators, attorneys, clergymen, law enforcement officers, coroners, medical investigators, psychologists, and administrators of child care facilities are mentioned by at least one or more states.

Five states do not follow the general pattern. These states do not designate a specific target group, but rather impose a legal obligation upon *any person* who has "knowledge" (Tennessee), "reason to believe" (Indiana), "cause to believe" (Texas and Utah), or "cause to suspect" (New Hampshire) that injury has been inflicted.

In addition to the five states discussed above, 17 others supplement the requirements that specified professional target groups report by placing a statutory duty to report on "any other person" who encounters a child who may have sustained an injury by other than accidental means.

Broadening the law's coverage, in terms of who reports, results in putting into legislative mandate the moral obligation of all citizens to come to the aid of neglected, abused and exploited children by invoking in their behalf the protective social services of the community. If we accept the concept that casefinding, in this context, is a universal obligation of all responsible citizens and all community agencies, then translation of that obligation into legislative ukase is truly appropriate.

We believe a combination of the different patterns would result in more accurate casefinding. We must continue to single out special target groups such as medical practitioners and other professionals in contact with children, but adding a phrase like "and any other person having knowledge" would enhance the casefinding potential. The national experience of Child Protective Services documents that a larger proportion of reports come from relatives, neighbors and other nonprofessional sources. Their inclusion would provide for them the protective immunities granted to target professional groups cited in the law.

7. Report – How Made

An overwhelming majority of the states emphasize the importance of urgent action in reporting suspected inflicted injury. Usual language is the phrase, "an immediate oral report shall be made by telephone or otherwise." Another common phrase is "forthwith by telephone or otherwise." Most of the states calling for an immediate oral report have the added requirement that this be followed by a report in writing.

The usual requirement is that the reporter furnish identifying data such as names and addresses of child and parents, the child's age, the nature and extent of the injuries, evidence of prior injuries, and any additional information that might be helpful in establishing the cause of the injuries and the identity of the perpetrator.

8. Report – To Whom

Twenty-three states specify that reports are to be made to a single receiving agency. In seventeen of these states the designated agency is a county or state department of welfare; five have designated a law enforcement agency to receive reports; and in one state all reports are made to the juvenile court. Of the jurisdictions not following one of the above pattersn, twenty-one permit the person reporting to notify one of two or more specified agencies, with the remaining states requiring reports to two or more specified agencies.

The designation of the receiving agency is one of the most critical elements of the reporting law. The nature and orientation of the agency first receiving the report will often determine the community's response to child abuse. In a number of states there is a clear inconsistency between the expressed intent of the reporting law and the functional nature of the agency designated to implement the law. A detailed discussion of this point follows in Section III, "Analysis and Comments."

9. Mandate to Receiving Agency

The degree of protection which the community makes available to abused children will depend, in great part, on what the agency designated to receive the report does about that report. The speed with which it acts, how responsibly it provides service and its interpretation of what is expected of it in these cases, all bear directly on this point.

Legislative action could add a measure of control if the law provided direction or guidelines to indicate what type of action is expected and to impose specific responsibilities upon the agency charged with receiving the report. To a greater or lesser extent, 44 states and Guam incorporated a specific mandate to the receiving agency. These mandates carry more explicit direction, require particular action or permit options for discretionary action by the designated agencies.

10. Immunity

An important element of the law is the provision which grants immunity to those reporting under the act. The immunity is against the possibility of criminal or civil action as a consequence of having made the report. The medical profession, a special target group in the law, thinks itself particularly vulnerable to lawsuits without such protection. Thus, inclusion of immunity provides some freedom from fear of retaliation by angry and, frequently, disturbed parents

All fifty states, the District of Columbia, Guam and the Virgin Islands include an immunity clause in their law.

11. Waivers

Because the medical profession expressed concern over the propriety of divulging confidential matter disclosed to them in the doctor-patient relationship, reporting acts provide a waiver. Thus, a doctor is freed from legal or ethical restrictions against revealing confidential information in 39 states, the District of Columbia, Guam and the Virgin Islands.

There is a like privilege between a husband and wife in many states. Neither may divulge information damaging to the other in any criminal procedure without a release from the spouse against whom the evidence is being given. Many of the reporting laws make the husband-wife privilege inapplicable in child abuse cases because quite frequently the only witnesses are the parents themselves. Explicit waivers of this privilege are found in 31 states, the District of Columbia and the Virgin Islands. In nine more states and in Guam the statutory language is not clear but there is inference to support thinking that this waiver is included. In these states the law grants a waiver of the doctor-patient and "similar" privilege, or it provides that any privilege recognized by law or a professional code of ethics is not applicable in proceedings involving child abuse.

In all but three states it is clear that the privileged status of attorney-client communications is preserved in the absence of an express waiver by the client. Alabama's reporting law, however, provides that "The doctrine of privileged communication shall not be a ground for excluding any evidence regarding a child's injuries or the cause thereof," and Nevada makes inapplicable in abuse cases "all privileges against disclosure recognized by Nevada law." The Alabama and Nevada statutes can conceivably be construed to abrogate the traditional attorney-client privilege, although such an interpretation would raise serious questions relating to the desirability of such clauses, and, perhaps, even their constitutionality.

12. The Penalty Clause

The penalty clause is a provision in the reporting law which makes it a misdemeanor for a person to willfully violate provisions of the act. Failure to report when one of the persons designated in the law has reason to believe that a child may have received inflicted, rather than accidental, injuries is punishable as a misdemeanor in a number of states. The underlying philosophy for the inclusion of a penalty clause is that no action can be mandated by law without also providing a penalty for failure to comply with that legal obligation. It is a device for enforcing the law.

There is a considerable difference of opinion with respect to the value of a penalty clause in a law such as this. A penalty clause is found in the laws of 29 states, Guam and the Virgin Islands.

13. Central Registry

Thirty-three states incorporate into their reporting law a requirement that some governmental unit at state level maintain a register of all reported cases of suspected child abuse. In 30 states the State Department of Social Services is charged with this responsibility. In California the register is maintained by the State Bureau of Criminal Identification and Investigation; in South Carolina the county departments of public welfare maintain the registers; and in Virginia responsibility is given to the Bureau of Vital Statistics, State Department of Health.

These central registries may serve two principal purposes: They may be used to gather data on the incidence and characteristics of abuse and neglect; and they may be utilized as a resource for identifying repeated abuses of the same child or of other children in the same family.

Since child abuse and neglect laws are undergoing revision in the various states, contact The American Humane Association, Denver, Colorado 80201, for current information.

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CHILD ABUSE:
ATTEMPTS TO SOLVE THE PROBLEM BY REPORTING LAWS

By Rowine Hayes Brown, M.D., J.D.*

Although world history is replete with evidence of infanticide, maiming, and other harsh treatment of children throughout the centuries,[1] society has not yet been able to assure protection of its children from malicious acts inflicted by the parents or others in close contact with them. During the last 12 years, physicians, social workers, lawyers and the public have become deeply concerned and aware of the increasing numbers of children who are either being killed or physically and/or mentally damaged, by their parents or those who should be their protectors. In my own experience at Cook County Hospital,[2] I have observed over 500 young children hospitalized because of severe physical abuse. 15% of these children were under 1 year of age; 66% were 3 years of age or less; and approximately 10% died as a result of their injuries.

Growing concern over this problem resulted in the enactment of child abuse reporting laws, the majority of which were modeled after a prototype suggested by the Children's Bureau.[3] The depth of concern in the United States with child abuse is measured by the fact that within a 4 year period, all American states plus the District of Columbia and the Virgin Islands had enacted "Battered Child Reporting Laws". The first such state statute was passed in California in 1963 and the last in Hawaii in 1967.[4]

In this article I will attempt to describe and analyze these statutes. The primary purpose of these reporting laws is to bring into the open and to identify children who are being abused, so that they may receive required therapy and protection.[5] A secondary purpose is that mandatory reporting will bring to light the true incidence of abuse and demonstrate the magnitude of the problem.[6] Reporting statutes would be ineffective unless reported children are, in fact, protected from further injury and offered a chance of a brighter life with a foster family, should remaining at home prove impossible or unsafe.

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Child protection and welfare must be provided by agencies trained in such disciplines, to whom abused children may be referred subsequent to their being reported.

Mandatory v. Permissive Reporting

Statutes making reporting of child abuse incidents mandatory exist in all but six States. Permissive reporting is suggested in Alaska, Missouri, New Mexico, North Carolina, Texas and Washington, but not required.

Who is Required to Report

The model statute suggested by the U.S. Children's Bureau places the duty to report primarily on physicians and other medical practitioners due to the fact that children are brought to physicians for treatment of their injuries and the doctor could be the first to suspect the diagnosis of child abuse. A physician also would better know the truth about injuries a child received, rather than having to accept the distorted story of the facts explained by the mother or other historian. The classification of persons charged with reporting was limited due to the fact that an immunity clause was sought by the majority of states in their child abuse laws. It was felt that the larger the scope of the reporting group requesting immunity, the smaller the chance that the legislature would enact an immunity clause to cover all of them. Immunity does not deprive one of his constitutional rights to sue, but precludes monetary recovery.

There are three states[7] whose law simply states that "any person" may file a report. There are 47 states where physicians and other specified persons are to file reports, and in 23 of these states[8] only physicians are to report. Illinois, which required reporting only by physicians, amended its Child Abuse Act[9] in 1973 to include reporting by others. 20 states[10] include nurses; 12[11] include social workers; 12[12] include teachers or school principals. Other states have added laboratory technicians,[13] pharmacists,[14] dentists,[15] law enforcement officers,[16] Christian Science practitioners,[17] attorneys,[18] clergymen,[19] coroners,[20] undertakers[21] and embalmers.[22]

What Injuries Are to be Reported

Although a physician on preliminary examination is unable to determine who inflicted injuries upon a child, he is usually able to determine what injuries were caused other than by an unavoidable accident. The physician will be suspicious of child abuse upon perceiving:[23]

1. any very young child with any severe injury,
2. any child with multiple injuries

in existence at the same time,
3. any child with repetitive trauma,
4. any child with many scars, or
5. any child whose injuries could not be caused in the manner stated in the history.

As suggested by the Children's Bureau,[24] the majority of child abuse statutes require reporting of "serious physical injury or injuries inflicted upon him other than by accidental means by a parent or other person responsible for his care". The majority of statutes do not define the terms "abuse" or "neglect" and those that do (Maryland and Oregon) are vague. A few states (New York, Ohio, Tennessee, Illinois) direct the reporting of an injury caused by "neglect" which is again a situation difficult to interpret.

None of the original child abuse reporting laws required reporting of a dead child, except in Arkansas where coroners report and in Tennessee where undertakers and embalmers report. Illinois has amended its child abuse act to include dead children. Following the reported death of a child, an investigation of the family circumstances may save his siblings from a similar fate.

"Malnutrition" must be reported in Illinois, New Mexico, and South Dakota. Often children who are physically abused are generally neglected and may be improperly fed, or even starved.

To Whom Reports Are Made

The method of handling cases will depend somewhat upon the agency receiving the report under the statute, usually either: Police, the prosecutor, Department of Social Welfare, or the Juvenile Court. The original plan to report to the police was based upon the fact these departments are always open and that their help is always available. Many states still require reporting to police.[25] However, such action stresses punitive aspects of abuse. As a result, the Children's Bureau and the majority of workers in child abuse today favor reporting to a public child welfare agency,[26] when such agency is authorized to provide child protective services. Some states allow reporting to a welfare agency in addition to police.[27] In only 4 states, the primary responsibility is that of the welfare agency. In others, reports to be made to the Juvenile Court,[28] 4 to the local prosecutor,[29] one to a peace officer,[30] one to the medical examiner.[31]

The investigation of the home circumstances and recommendations for the solution of the particular child abuse situation are the important elements for determination. These, as a rule, are performed more competently and with more understanding by a social service or welfare agency.

Central Registries

The maintenance of a state-wide registry is an important part of the child abuse program.[32] Physicians and social service workers desire such registries in order to more rapidly determine if the child with which they are now concerned has in fact been previously reported as a battered child. Such a registry, is of additional value for statistical studies and research. In 4 states, central registries were established by the statute.[33] In Illinois, the central registry is located in the main offices of the Department of Children and Family Services,[34] the welfare agency to whom reports must be made, and their data is available only to their own personnel. Practicing physicians derive little or no benefit from it. In some jurisdictions, registries have been created by social agencies and others on a voluntary basis.[35] The existence of a central registry used for anything but statistical purposes has raised sensitive issues of privacy (Col. Law Review p. 31). Diligence and caution should be exercised so that cases in which abuse was not found to have occurred can be removed from the registry.

Immunity
From Liability For Reporting

Physicians have heretofore feared legal liability resulting from reporting cases of suspected child abuse. They particularly fear that a finding of child abuse might not be established following their report. In an attempt to reduce that fear, statutory enactments have been passed to the effect that reporting physicians are now clothed with statutory immunity from civil and/or criminal suit provided they report in good faith and/or participate in the subsequent judicial proceeding resulting from such reporting.[36] In only 4 states,[37] immunity clauses are omitted from the child abuse statutes.

In 30 of our states,[38] the statutes relate that the physician-patient privilege is not a bar to testimony on the basis of privileged communication and therefore in these jurisdictions, physicians would be expected to disclose in a forum, facts learned in the course of their physician-patient relationship. Under these circumstances, they would not be considered as betraying professional secrets to the detriment of their patient.

Liability For Failure to Report

A child or parent is unlikely to prevail in his suit against a physician, who has in good faith reported a case of child abuse involving either or both to the authorities. Many of the reporting statutes carry a criminal penalty for failure to report. Such penalties include fines up to $500[39] and/or incarceration for as long as one year.[40]

If a physician fails to report his findings of child abuse when he has a statutory duty to do so he may be liable to prosecution and even incur civil liability. In most states, violation of a criminal statute is "negligence per se". If the physician fails to carry out his mandatory duty to report he has precluded the intervention of the child protective agencies to prevent further injury to the child and such failure could result in a civil cause of action against him in favor of infants who suffer abuse.[41]

Results of the Legislation

After the announcement of the mandatory reporting laws, numerous reports of child abuse were received throughout the United States. The number of reports were far in excess of those anticipated. As a result, agencies were swamped with reports and were handicapped by inadequate personnel. There were lags in "intake", records, investigations, preparing and getting cases to court, etc. Publicity through symposia, panels, speeches, press and professional literature focused on this problem. Many children who were illegally abused were not reported and many who were not so abused, were reported.

Child abuse continues to be a major social problem today affecting our young children. Changes of the social milieu could decrease its incidence, but until that Utopia arrives, we must provide better child protective services. Our first line of attack should be the child protective agencies, with juvenile courts as a backup facility. Overcrowded juvenile court calendars should have their work loads reduced so that the child who comes to court for deliberation concerning his future, will not have his life's course decided in a far too brief hearing.

Is Further Legislation Needed?

Many people feel child abuse laws should become more rigid. Some feel police should be involved at the onset and that more serious penalties should be enacted to punish physicians who fail to report cases. In my opinion, the problem cannot be "legislated out of existence".[42] If child welfare agencies are to be given more responsibility concerning these cases, their authority and responsibilities should be spelled out in detail. Adequate appropriations must be included in state budgets to fund the reporting plan and to provide for preventative and rehabilitative services. Implementation of good laws often depends on appropriations, and often fails due to the lack thereof.

Protective services for children are often inadequate and governmental appropriations are negligible or non-existent (only Illinois and Massachusetts have appropriated anything).[43] Rehabilitation and therapeutic services for the abusers are often inadequate or nonexistent; foster homes for temporary child placement have at times been no better than the homes in which the original abuse occurred; decisions concerning the child and his future are often made in court without any legal representation on behalf of the child; physicians are still reluctant to appear in court to testify in the child's behalf.

Strict adherence to existing laws, lawyers and officials involved diligently attending to their duties, adequate funding for agencies and services, plus the "watch dog" attitudes of dedicated people and the press could clear up many of the above recited deficiencies.

1. R.C. Helfer & C.H. Kempe, The Battered Child 8 (1968). Infanticide was practiced by the ancient Egyptians, Greeks, and Romans.
2. These children were hospitalized at the Cook County Children's Hospital between July 1, 1965, and June 30, 1973.
3. In 1962 the Children's Bureau of the Department of Health, Education and Welfare, conducted a symposium on this problem in Washington, D.C., and suggested a model statute.
4. For a listing of each statute, see Paulsen Child Abuse Reporting Laws. The Shape of the Legislation, Columbia Law Review, Vol. 67, No. 1, January 1967, p. 2.
5. Brown, R.H., Fox, E.S., Hubbard, E.L. Medical and Legal Aspects of the Battered Child Syndrome; Chicago-Kent Law Review, Vol. 50, No. 1, (1973), p. 63.
6. Brown, R.H., The Battered Baby, 76 Chicago Medicine, No. 6 (1973).
7. Nebraska, Tennessee, Utah.
8. Arizona, California, Colorado, Connecticut, Delaware, Florida, Idaho, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, New Hampshire, New Jersey, Ohio, Pennsylvania, Rhode Island, South Carolina, Texas, Vermont, Washington, Wisconsin.
9. Illinois H.B. 32, 78th General Assembly, 1st Session (1973).
10. Alabama, Alaska, Arkansas, Georgia, Iowa, Kansas, Maryland, Minnesota, Mississippi, Montana, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Virginia, Wisconsin, Wyoming.
11. Alabama, Alaska, Georgia, Kansas, Maryland, Montana, Nevada, New Mexico, North Carolina, Ohio, West Virginia, Wisconsin.
12. Alabama, Alaska, California, Illinois, Maryland, Montana, Nevada, New Mexico, North Carolina, Ohio, West Virginia, Wisconsin.
13. Indiana, Wyoming.
14. Alabama, Arkansas, Minnesota, Pennsylvania, Wyoming.
15. Illinois, Iowa, Mississippi, Nevada, New York, Oklahoma, South Dakota.
16. South Dakota
17. Illinois
18. Nevada
19. New Mexico and Nevada.
20. Arkansas
21. Tennessee
22. Tennessee
23. See note 5 supra (p. 49).
24. Children's Bureau, U.S. Dept. of Health, Education and Welfare; The Abused Child - Principles and Suggested Language for Legislation and Reporting of the Physically Abused Child (1963).
25. Arizona, Arkansas, California, Colorado, Kentucky, Louisiana, Missouri, and Virginia.
26. Reports are made primarily to a child welfare agency in Idaho, Illinois, Massachusetts, New York, North Carolina, Vermont, Wyoming.
27. Alabama, Connecticut, Indiana, Maine, Michigan, Oklahoma, Pennsylvania, South Carolina, Texas, Utah, Wisconsin.
28. Delaware, Florida, Kansas, Mississippi, South Dakota, Tennessee, Washington.
29. Montana, Nebraska, New Jersey, West Virginia.
30. Ohio
31. Oregon
32. See note 4 supra (p. 24).
33. California, Illinois, Maryland, Virginia.
34. The Department of Children & Family Services is an agency of the State of Illinois. It is concerned with social and welfare problems relevent to children. It is the agency to whom reports of child abuse must be made in Illinois.
35. In states: Colorado, Florida, North Dakota, Utah; and in cities; Cincinnati, Milwaukee, New York City.
36. See note 5, supra (p. 47).
37. Minnesota, Oregon, Wisconsin.
38. Alabama, Alaska, Arizona, Arkansas, California, Delaware, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Montana, Missouri, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Utah, Virginia, Washington, Wisconsin, Wyoming.
39. Alabama $500, Arizona $100, Arkansas $500, Kentucky $10-$100, Louisiana $100, Missouri $100, Nebraska $100, New Hampshire $500, Pennsylvania $300, South Dakota $100, Utah $25, Wisconsin $100, Virgin Islands $500.
40. Alabama 6 mos., Arizona 10 days, Arkansas 6 mos., Louisiana 10 days, Missouri 6 mos., Pennsylvania 90 days, South Dakota 30 days, Wisconsin 6 mos., and Virgin Islands 1 year.
41. See note 5 supra (p. 63, Footnote 122).
42. See note 6 supra.
43. When their initial child abuse statutes were enacted Illinois appropriated $50,000 and Massachusetts $100,000.

Public Law 93–247
93rd Congress, S. 1191
January 31, 1974

An Act

To provide financial assistance for a demonstration program for the prevention, identification, and treatment of child abuse and neglect, to establish a National Center on Child Abuse and Neglect, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Child Abuse Prevention and Treatment Act".

Child Abuse Prevention and Treatment Act
88 STAT. 4

THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT

SEC. 2. (a) The Secretary of Health, Education, and Welfare (hereinafter referred to in this Act as the "Secretary") shall establish an office to be known as the National Center on Child Abuse and Neglect (hereinafter referred to in this Act as the "Center").

88 STAT. 5
Establishment

(b) The Secretary, through the Center, shall—

(1) compile, analyze, and publish a summary annually of recently conducted and currently conducted research on child abuse and neglect;

Annual research summary.

(2) develop and maintain an information clearinghouse on all programs, including private programs, showing promise of success, for the prevention, identification, and treatment of child abuse and neglect.

Information clearinghouse

(3) compile and publish training materials for personnel who are engaged or intend to engage in the prevention, identification, and treatment of child abuse and neglect.

(4) provide technical assistance (directly or through grant or contract) to public and nonprofit private agencies and organizations to assist them in planning, improving, developing, and carrying out programs and activities relating to the prevention, identification, and treatment of child abuse and neglect.

(5) conduct research into the causes of child abuse and neglect, and into the prevention, identification, and treatment thereof; and

(6) make a complete and full study and investigation of the national incidence of child abuse and neglect, including a determination of the extent to which incidents of child abuse and neglect are increasing in number or severity.

Study

(c) The Secretary may carry out his functions under subsection (b) of this section either directly or by way of grant or contract.*

Amended January 3, 1975 by P.L. 93-644.

DEFINITION

SEC. 3. For purposes of this Act the term "child abuse and neglect" means the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Secretary.

DEMONSTRATION PROGRAMS AND PROJECTS

Grants and contracts.

SEC. 4. (a) The Secretary, through the Center, is authorized to make grants to, and enter into contracts with, public agencies or nonprofit private organizations (or combinations thereof) for demonstration programs and projects designed to prevent, identify, and treat child abuse and neglect. Grants or contracts under this subsection may be—

88 STAT. 6

(1) for the development and establishment of training programs for professional and paraprofessional personnel in the fields of medicine, law, education, social work, and other relevant fields who are engaged in, or intend to work in, the field of the prevention, identification, and treatment of child abuse and neglect; and training programs for children, and for persons responsible for the welfare of children, in methods of protecting children from child abuse and neglect;

(2) for the establishment and maintenance of centers, serving defined geographic areas, staffed by multidisciplinary teams of personnel trained in the prevention, identification, and treatment of child abuse and neglect cases, to provide a broad range of services related to child abuse and neglect, including direct support and supervision of satellite centers and attention homes, as well as providing advice and consultation to individuals, agencies, and organizations which request such services;

(3) for furnishing services of teams of professional and paraprofessional personnel which are trained in the prevention, identification, and treatment of child abuse and neglect cases, on a consulting basis to small communities where such services are not available; and

(4) for such other innovative programs and projects, including programs and projects for parent self-help, and for prevention and treatment of drug-related child abuse and neglect, that show promise of successfully preventing or treating cases of child abuse and neglect as the Secretary may approve.

Not less than 50 per centum of the funds appropriated under this Act for any fiscal year shall be used only for carrying out the provisions of this subsection.

Grants to States.

(b) (1) Of the sums appropriated under this Act for any fiscal year, not less than 5 per centum and not more than 20 per centum may be used by the Secretary for making grants to the States for the payment of reasonable and necessary expenses for the purpose of assisting the States in developing, strengthening, and carrying out child abuse and neglect prevention and treatment programs.

(2) In order for a State to qualify for assistance under this subsection, such State shall—

(A) have in effect a State child abuse and neglect law which shall include provisions for immunity for persons reporting instances of child abuse and neglect from prosecution, under any State or local law, arising out of such reporting;

(B) provide for the reporting of known and suspected instances of child abuse and neglect;

(C) provide that upon receipt of a report of known or suspected instances of child abuse or neglect an investigation shall be initiated promptly to substantiate the accuracy of the report, and, upon a finding of abuse or neglect, immediate steps shall be taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect;

(D) demonstrate that there are in effect throughout the State, in connection with the enforcement of child abuse and neglect laws and with the reporting of suspected instances of child abuse and neglect, such administrative procedures, such personnel trained in child abuse and neglect prevention and treatment, such training procedures, such institutional and other facilities (public and private), and such related multidisciplinary programs and services as may be necessary or appropriate to assure that the State will deal effectively with child abuse and neglect cases in the State;

(E) provide for methods to preserve the confidentiality of all records in order to protect the rights of the child, his parents or guardians;

88 STAT. 7

(F) provide for the cooperation of law enforcement officials, courts of competent jurisdiction, and appropriate State agencies providing human services;

(G) provide that in every case involving an abused or neglected child which results in a judicial proceeding a guardian ad litem shall be appointed to represent the child in such proceedings;

(H) provide that the aggregate of support for programs or projects related to child abuse and neglect assisted by State funds shall not be reduced below the level provided during fiscal year 1973, and set forth policies and procedures designed to assure that Federal funds made available under this Act for any fiscal year will be so used as to supplement and, to the extent practicable, increase the level of State funds which would, in the absence of Federal funds, be available for such programs and projects;

(I) provide for dissemination of information to the general public with respect to the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat instances of child abuse and neglect; and

(J) to the extent feasible, insure that parental organizations combating child abuse and neglect receive preferential treatment.

(3) Programs or projects related to child abuse and neglect assisted under part A or B of title IV of the Social Security Act shall comply with the requirements set forth in clauses (B), (C), (E), and (F) of paragraph (2).

49 Stat. 627.
81 Stat. 911.
42 USC 601, 620.

(c) Assistance provided pursuant to this section shall not be available for construction of facilities; however, the Secretary is authorized to supply such assistance for the lease or rental of facilities where adequate facilities are not otherwise available, and for repair or minor remodeling or alteration of existing facilities.

(d) The Secretary shall establish criteria designed to achieve equitable distribution of assistance under this section among the States, among geographic areas of the Nation, and among rural and urban areas. To the extent possible, citizens of each State shall receive assistance from at least one project under this section.

(e) For the purposes of this section, the term "State" includes each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, American Samoa, the Virgin Island, Guam and the Trust Territories of the Pacific.*

Amended
January 3, 1975
by P.L. 93-644.

AUTHORIZATIONS

SEC. 5. There are hereby authorized to be appropriated for the purposes of this Act $15,000,000 for the fiscal year ending June 30, 1974, $20,000,000 for the fiscal year ending June 30, 1975, and $25,000,000 for the fiscal year ending June 30, 1976, and for the succeeding fiscal year.

ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

Membership

Functions

SEC. 6. (a) The Secretary shall, within sixty days after the date of enactment of this Act, appoint an Advisory Board on Child Abuse and Neglect (hereinafter referred to as the "Advisory Board"), which shall be composed of representatives from Federal agencies with responsibility for programs and activities related to child abuse and neglect, including the Office of Child Development, the Office of Education, the National Institute of Education, the National Institute of Mental Health, the National Institute of Child Health and Human Development, the Social and Rehabilitation Service, and the Health Services Administration. The Advisory Board shall assist the Secretary in coordinating programs and activities related to child abuse and neglect administered or assisted under this Act with such programs and activities administered or assisted by the Federal agencies whose representatives are members of the Advisory Board. The Advisory Board shall also assist the Secretary in the development of Federal standards for child abuse and neglect prevention and treatment programs and projects.

Report to President and Congress

(b) The Advisory Board shall prepare and submit, within eighteen months after the date of enactment of this Act, to the President and to the Congress a report on the programs assisted under this Act and the programs, projects, and activities related to child abuse and neglect administered or assisted by the Federal agencies whose representatives are members of the Advisory Board. Such report shall include a study of the relationship between drug addiction and child abuse and neglect.

(c) Of the funds appropriated under section 5, one-half of 1 per centum, or $1,000,000, whichever is the lesser, may be used by the Secretary only for purposes of the report under subsection (b).

COORDINATION

SEC. 7. The Secretary shall promulgate regulations and make such arrangements as may be necessary or appropriate to ensure that there is effective coordination between programs related to child abuse and neglect under this Act and other such programs which are assisted by Federal funds.

Approved January 31, 1974.

*Amendments Section 2(c) and Section 4(e) added by P.L. 93-644, approved January 3, 1975.

LEGISLATIVE HISTORY

HOUSE REPORT No. 93-685 (Comm. on Education and Labor).
SENATE REPORT No. 93-308 (Comm. on Labor and Public Welfare).
CONGRESSIONAL RECORD, Vol. 119 (1973):
    July 14, considered and passed Senate.
    Dec. 3, considered and passed House, amended.
    Dec. 20, Senate agreed to House amendments with amendments.
    Dec. 21, House concurred in Senate amendments.

CHILD ABUSE: MARYLAND STATE CHILD MALTREATMENT LAW

Article 27, Section 35A, Annotated Code of Maryland

An ACT concerning

Child Abuse

For the purpose of expanding the definition of child abuse, defining sexual abuse, requiring reports to include information on sexual abuse; clarifying language; providing immunity from civil liability and criminal penalty for physicians or health care institutions examining or treating a child without the consent of the parents or guardian in certain cases; and providing for payment to physicians or health care institutions for charges incurred.

By repealing and re-enacting, with amendments,

Article 27 - Crimes and Punishments
Section 35A
Annotated Code of Maryland
(1971 Replacement Volume and 1973 Supplement)

Section 1. Be it enacted by the General Assembly of Maryland, that Section 35A of Article 27 - Crimes and Punishments of the Annotated Code of Maryland (1971 Replacement Volume and 1973 Supplement) be and it is hereby repealed and re-enacted, with amendments, to read as follows:

Article 27 - Crimes and Punishments

35A.

The General Assembly hereby declares as its legislative intent and purpose the protection of children who have been the subject of abuse by mandating the reporting of suspected abuse, by extending immunity to those who report in good faith, by requiring prompt investigations of such reports and by causing immediate, cooperative efforts by the responsible agencies on behalf of such children.

(a) Any parent, adoptive parent or other person who has the permanent or temporary care or custody or responsibility for the supervision of a minor child under the age of eighteen years who causes abuse to such minor child shall be guilty of a felony and upon conviction shall be sentenced to not more than fifteen years in the penitentiary.

(b) Wherever used in this section, unless the context clearly indicates otherwise:

1. "Health practitioner" includes any physician, surgeon, psychologist, dentist and any other person authorized to engage in the practice of healing, any resident or intern in any of these professions, and any registered or licensed practical nurse attending or treating a child in the absence of a practitioner of any of these professions.

2. "Child" means any person under the age of eighteen (18) years.

3. "Local department of social services" and "local state's attorney" refer to the jurisdiction in which the child lives, or where the abuse is alleged to have taken place, if different.

4. "Educator or social worker" shall mean any teacher, counselor, or other professional employee of any school, public, parochial or private, or any caseworker or social worker or other professional employee of any public or private social, educational, health or social service agency or any probation or parole officer or any professional employee of a correctional institution.

5. "Law-enforcement officer" shall mean any police officer, or State trooper in the service of the State of Maryland or any county or municipality thereof.

6. "Law-enforcement agency' shall mean any police department, Bureau or force of any county or Baltimore City, any police department, bureau or force of any incorporated municipality or the Maryland State Police.

7. "Abuse" shall mean any: (A) physical injury or injuries sustained by a child as a result of cruel or inhumane treatment or as a result of malicious act or acts by any parent, adoptive parent or other person who has the permanent or temporary care or custody or responsibility for supervision of a minor child. (B) Any sexual abuse of a child, whether physical injuries are sustained or not.

8. "Sexual Abuse" shall mean any act or acts involving sexual molestation or exploitation, including but not limited to incest, rape, carnal knowledge, sodomy or unnatural or perverted sexual practices on of child by any parent, adoptive parent or other person who has the permanent or temporary care or custody or responsibility for supervision of a minor child.

(c) Every health practitioner, educator or social worker or law-enforcement officer, who contacts, examines, attends, or treats a child and who believes or has reason to believe that the child has been abused is required to make a report in the form and manner provided in the following subsection, notwithstanding any other section of the law relating to privileged communications; provided, however, that if the educator or social worker or law-enforcement officer or health practitioner examines, attends, or treats the child in the capacity of a member of the staff of a hospital, public health agency, child-care institution, juvenile detention center, school or similar institution, the health practitioner, educator or social worker or law-enforcement officer, shall also immediately notify and give all necessary information required by this section to the person or persons in charge of the institution or a designated representative thereof.

(d) Each such report made pursuant to the provisions of subsection (C) shall be made to the agencies as provided for hereinafter, both orally and in written form; both the reports to be made as soon as is reasonably possible in the case, the written report must be made within forty-eight (48) hours of the contact, examination, attention or treatment which disclosed the existence of possible abuse. The oral report shall be made either by telephone or to the appropriate law-enforcement agency. The agency to which the report is made shall immediately notify the other agency. Nothing however, shall prohibit the local department of social services and the appropriate law-enforcement agency from jointly agreeing to cooperative arrangements. The written report required to be made shall be made in all cases to the local department of social services and a copy sent to the local State's attorney.

The oral and written reports shall contain the following information, or as much thereof as the person making the report shall be able in the circumstances to furnish:

(1) The name and home address or addresses of the child or children and the parent or other persons responsible for the care of the child or children in question;

(2) The present whereabouts of the child or children if not the same as the home address or addresses;

(3) The age or ages of the child or children;

(4) The nature and extent of the injuries or injury or sexual abuse of the child or children in question, including any evidence or information available to the person or agency rendering the report of previous injury or injuries possibly resulting from abuse or previous sexual abuse.

(5) All such information available to the reporter which would be of aid in establishing the cause of the injuries or injury and identity of the person or persons responsible therefore.

(e) Any person other than a health practitioner, educator or social worker, or law-enforcement officer who has reason to believe a child is abused shall so report to the local department of social services or to the appropriate law-enforcement agency. The agency to which the report is made shall immediately notify the other agency. Nothing, however, shall prohibit the local department of social services or the appropriate law-enforcement agency from jointly agreeing to cooperative arrangements. A report made by such person may be either written or oral, or both, and such report shall be regarded as a report within the provisions of this section, whether or not the report contains all of the required information provided for in subsection (d).

(f) The local department of social services or the appropriate law-enforcement agency as the case may be, or both, if jointly agreed upon, shall make a thorough investigation promptly upon receiving a report of probable violation of this section, and the primary purpose of the investigation shall be the protection of the welfare or the child or children. The investigation shall include a determination of the nature, extent and cause or causes of the abuse, if any; upon validation of the suspected abuse, the investigation shall then ascertain the identity of the person or persons responsible therefor, the name, age and condition of other children in the same household, an evaluation of the parents and the home environment, and all other facts or matters found to be pertinent. The local department of social services, and the appropriate law-enforcement agency if that agency participated in the investigation, shall render a complete written report of its findings to the local State's attorney within five (5) working days of the completion of the investigation, which shall be within ten (10) days of the receipt of the oral or written report first disclosing to the local department of social services the existence of a possible violation of this section. Upon request by the local department of social services, the local State's attorney shall assist in the investigation.

(f-1) If, in the course of the investigation conducted by the local department of social services under the provisions of sub-section (e), a representative of the department has probable cause to believe that the child or children is or are in serious physical danger and that an emergency situation exists, the representative may enter the household, if the representative has been previously denied the right of entry. A law-enforcement officer shall accompany the representative, and he may use reasonable force, if necessary, to assure that the representative is able to gain entry. If the danger proves to be genuine, the representative may remove the child or children from the household temporarily without prior approval by the juvenile court.

If the child is removed from the household under the provisions of this section, the local department of social services shall have the child thoroughly examined by a physician, and the report of this examination shall be included in the report made under the provisions of subsection (e) within the time specified.

(g) Based on their findings, the local department of social services shall render the appropriate service in the best interests of the child, including, when indicated, petitioning the juvenile court in behalf of the child for the added protection to the child which either commitment or custody would provide. The local State's attorney and other appropriate law-enforcement agencies having jurisdiction shall take such lawful action as may be appropriate in the circumstances.

(h) (1) Any person, including a health practitioner, educator, or social worker or law-enforcement officer, participating in the making of a good faith report pursuant to this section or participating in an investigation or in a judicial proceeding resulting therefrom shall in so doing be immune from any civil liability or criminal penalty that might otherwise be incurred or imposed as a result thereof.

(2) Any physician licensed to practice medicine in Maryland who shall be presented with a child pursuant to an order of a court of competent jurisdiction, or by a law-enforcement officer or by a representative of a local department of social services who states he has the child in his custody as a child whom he has reason to believe is an abused child, shall examine said child with or without the consent of a parent, guardian or custodian of said child to determine the nature and extent of injury or injuries or sexual abuse, if any, to said child. Any such physician and any public or private health care institution with which he might be affiliated or to which the child might be brought, and those persons working under the control or supervision of said physician or such health care institution who shall so examine or participate in the examination of said child shall be immune from civil liability and/or criminal penalty that might result from failure to obtain consent from the parent, guardian or custodian to examine the child.

(3) Any physician licensed to practice medicine in Maryland who shall be presented with a child pursuant to an order of a court of competent jurisdiction, or by a law-enforcement officer or by a representative of a local department of social services who states he has the child in his custody as a child whom he has reason to believe is an abused child, who shall have examined any child pursuant to the provisions of section (1) who shall determine that immediate medical treatment is indicated may provide such treatment to said child with or without the consent of a parent, guardian, or custodian of said child. Any such physician or health care institution and those persons working under the control or supervision of said physician or health care institution so treating said child shall be immune from civil liability and/or criminal penalty that might result from the failure to obtain the consent from the parent, guardian or custodian for the treatment of the child.

(4) Whenever any child is examined or treated pursuant to section (H) (2) and section (H) (3) the local department of Health and Mental Hygiene shall be responsible for the payment of all reasonable physician and/or health care institution charges incurred and the parents or the guardian of the child shall be liable to the local department for such payments.

(i) The State Department of Social Services shall and each local department of social services may maintain a central registry of cases reported under this section, which data shall be furnished by the respective local departments of social services throughout the state of Maryland and this data shall be at the disposal of local departments of social services, social agencies, public health agencies, law-enforcement agencies, as well as licensed health practitioners and health and education institutions licensed or regulated by the State of Maryland.

Section 2. And be it further enacted, that this act shall take effect July 1, 1974.

CHILD NEGLECT: MARYLAND STATE CHILD MALTREATMENT LAW

Annotated Code of Maryland
Courts and Judicial Proceedings

Subtitle 8. Juvenile Causes

Section 3-801

(c) "Child" means a person under the age of 18 years.

(d) "Child in need of assistance" is a child who needs the assistance of the court because

(1) He is mentally handicapped or is not receiving ordinary and proper care and attention, and

(2) His parents, guardian, or custodian are unable or unwilling to give proper care and attention to the child and his problems provided, however, a child shall not be deemed to be in need of assistance for the sole reason he is being furnished non-medical remedial care and treatment recognized by State law.

Section 3-802

(a) The purposes of this subtitle are:

(1) To provide for the care, protection, and wholesome mental and physical development of children coming within the provisions of this subtitle and to provide for a program of treatment, training, and rehabilitation consistent with the child's best interests and the protection of the public interest;

(2) To remove from children committing delinquent acts the taint of criminality and the consequences of criminal behavior;

(3) To conserve and strengthen the child's family ties and to separate a child from his parents only when necessary for his welfare or in the interest of public safety:

(4) If necessary to remove a child from his home, to secure for him custody, care, and discipline as nearly as possible equivalent to that which should have been given by his parents.

(5) To provide judicial procedures for carrying out the provisions of this subtitle.

(b) This subtitle shall be liberally construed to effectuate these purposes.

Section 3-814 Taking child into custody.

(a) A child may be taken into custody by any of the following methods:

(1) Pursuant to an order of the court.
(2) By a law enforcement officer pursuant to the law of arrest.
(3) By a law enforcement officer or other person authorized by the court if he has reasonable grounds to believe that the child is in immediate danger from his surroundings and that his removal is necessary for his protection, or

(4) By a law enforcement officer or other person authorized by the court if he has reasonable grounds to believe that the child has run away from his parents, guardian, or legal custodian.

(b) If a law enforcement officer takes a child into custody he shall immediately notify, or cause to be notified, the child's parents, guardian, or custodian of the action. After making every reasonable effort to give notice, the law enforcement officer shall with all reasonable speed:
(1) Release the child to his parents, guardian, or custodian or to any other person designated by the court, upon their written promise to bring the child before the court when requested by the court, and such security for the child's appearance as the court may reasonably require, unless his placement in detention or shelter care is permitted and appears required by 3-815, or
(2) Deliver the child to the court or a place of detention or shelter care designated by the court.

(c) If a parent, guardian, or custodian fails to bring the child before the court when requested, the court may issue a writ of attachment directing that the child be taken into custody and brought before the court. The court may proceed against the parent, guardian, or custodian for contempt.

Section 3-815 Detention and shelter care prior to hearing.

(a) Only the court or an intake officer may authorize detention or shelter care.
(b) If a child is taken into custody, he may be placed in detention or shelter care prior to a hearing if:

(1) Such action is required to protect the child or person and property of others;
(2) The child is likely to leave the jurisdiction of the court: or
(3) There are no parents, guardian, or custodian or other person able to provide supervision and care for the child and return him to the court when required.

(c) If the child is not released, the intake officer shall immediately file a petition to authorize continued detention or shelter care. A hearing on the petition shall be held not later than the next court day, unless extended by the court upon good cause shown.

Reasonable notice, oral or written, stating the time, place, and purpose of the hearing, shall be given to the child and, if they can be found, his parents, guardian, or custodian. Detention and shelter care shall not be ordered for a period of more than 30 days unless an adjudicatory hearing is held.

(d) A child alleged to be delinquent may not be detained in a jail or other facility for the detention of adults, or in a facility in which children who have been adjudicated delinquent are detained.

(e) A child alleged to be in need of supervision or in need of assistance may not be placed in detention. If the child is alleged to be in need of assistance by reason of a mental handicap, he may be placed in shelter care facilities maintained or licensed by the Department of Health and Mental Hygiene or if these facilities are not available, then in a private home or facility located in Maryland and approved by the court. If the child is alleged to be in need of assistance for any other reason, or in need of supervision, he may be placed in shelter care facilities maintained or approved by the Department of Employment and Social Services, or the Juvenile Services Administration, or in a private home or shelter care facility approved by the court.

(f) The intake officer shall immediately give written notice of the authorization for detention or shelter care to the child's parent, guardian, or custodian, and to the court. The notice shall be accompanied by a statement of the reasons for taking the child into custody and placing him in detention or shelter care. This notice may be combined with the notice required under subsection (c).

Section 3-818 Study and examination of child, etc.

(a) After a petition has been filed, the court may direct the Juvenile Services Administration or other qualified agency designated by the court, to make a study concerning the child, his family, his environment, and other matters relevant to the disposition of the case. The report of the study is admissible as evidence at a waiver hearing and at a disposition hearing, but not at an adjudicatory hearing. However, the attorney for each party has the right to inspect the report prior to its presentation to the court, to challenge or impeach its findings, and to present appropriate evidence with respect to it.

(b) As part of the study, the child or any parent, guardian, or custodian may be examined at a suitable place by a physician, psychiatrist, psychologist, or other professionally qualified person.

Section 3-820 Disposition.

(a) If the court, after an adjudicatory hearing, adjudicates a child as being delinquent, in need of supervision, or in need of assistance, it shall hold a separate hearing to determine an appropriate disposition unless the hearing is waived in writing by all the parties.

(b) The overriding consideration in making a disposition is a program of treatment, training, and rehabilitation best suited to the physical, mental, and moral welfare of the child consistent with the public interest. The court may:

(1) Place the child on probation or under supervision in his own home or in the custody or under the guardianship of a relative or other fit person, upon terms the court deems appropriate;

(2) Commit the child to the custody or under the guardianship of the Juvenile Services Administration, a local department of social services, the Department of Health and Mental Hygiene, or a public or licensed private agency.

(c) A guardian appointed under this section has no control over the property of the child unless he receives that express authority from the court.

Section 3-821 Right to counsel.

A party is entitled to the assistance of counsel at every stage of any proceeding under this subtitle.

Section 3-822 Emergency medical treatment

The court may order emergency medical, dental, or surgical treatment of a child alleged to be suffering from a condition or illness which, in the opinion of a licensed physician or dentist, as the case may be, requires immediate treatment, if the child's parent, guardian, or custodian is not available or, without good cause, refuses to consent to the treatment.

Section 3-823 Limitations on place of commitment.

(a) A child may not be committed or transferred to a penal institution or other facility used primarily for the confinement of adults charged with or convicted of a crime, except pursuant to 3-816 (b).

(b) A child who is not delinquent may not be committed or transferred to a facility used for the confinement of delinquent children.

Section 3-826 Progress reports.

If a child is committed to an individual or to a public or private agency or institution, the court may require the custodian to file periodic written progress reports, with recommendations for further supervision, treatment, or rehabilitation.

Section 3-827 Order controlling conduct of person before court.

Pursuant to the procedure provided in the Maryland Rules, the court may make an appropriate order directing, restraining, or otherwise controlling the conduct of a person who is properly before the court, if:

(i) The court finds that the conduct:

  (a) Is or may be detrimental or harmful to a child over whom the court has jurisdiction; or
  (b) Will tend to defeat the execution of an order or disposition made or to be made; or
  (c) Will assist in the rehabilitation of or is necessary for the welfare of the child; and

(ii) Notice of the application or motion and its grounds has been given as prescribed by the Maryland Rules.

Section 3-828 Confidentiality and expungement of records.

(a) A police record concerning a child is confidential and shall be maintained separate from those of adults. Its contents may not be divulged, by subpoena or otherwise, except by order of the court upon good cause shown. This subsection does not prohibit access to and confidential use of the record by the Juvenile Services Administration or in the investigation and prosecution of the child by any law enforcement agency.

(b) A juvenile court record pertaining to a child is confidential and its contents may not be divulged, by subpoena or otherwise, except by order of the court upon good cause shown. This subsection does not prohibit access to and the use of the court record in a proceeding in the court involving the child, by personnel of the court, the State's attorney, counsel for the child, or authorized personnel of the Juvenile Services Administration.

(c) The court, on its own motion or on petition, and for good cause shown, may order the court records of a child sealed, and, upon petition or on its own motion, shall order them sealed after the child has reached age 21 years of age. After a child has reached 21 years of age, the court may, upon petition or on its own motion, expunge records of the child in a case in which an adjudication of the child as delinquent, in need of supervision or in need of assistance has not been made. If sealed, the court records of a child may not be opened, for any purpose, except by order of the court upon good cause shown.

Section 3-830 Parents liable for support after commitment.

After giving the parent a reasonable opportunity to be heard, the court may order either parent or both parents to pay a sum in the amount the court directs to cover the support of the child in whole or in part.

Section 3-831 Contributing to certain conditions of child.

(a) It is unlawful for an adult wilfully to contribute to, encourage, cause or tend to cause any act, omission, or condition which renders a child delinquent in need of supervision, or in need of assistance.

(b) A person may not be convicted under this section unless the child has been adjudicated delinquent, in need of supervision, or in need of assistance. However, the court may expunge the adjudication from the child's record and enter it as a finding in the adult's case.

(c) An adult convicted under this section is subject to a fine of not more than $500 or imprisonment for not more than two years, or both. The court may suspend sentence and place the adult on probation subject to the terms and conditions it deems to be in the best interests of the child and the public.

Section 3-832 Appeals in Montgomery County.

For purposes of Title 12 of this article, an action, decision, order, or judgment of the District Court in Montgomery County sitting as the juvenile court shall be treated in the same manner as if it had been made, done, or entered by a circuit court.

GUIDELINES FOR NEGLECT

The Social Service Administration of the Maryland Department of Human Resources applies the following guidelines for child neglect.

Malnourished; ill-clad; dirty; without proper shelter or sleeping arrangements; lacking appropriate health care

Unattended; without adequate supervision

Ill and lacking essential medical care

Denied normal experiences that produce feelings of being loved, wanted, secure (Emotional neglect)

Unlawfully kept from attending school

Exploited, overworked

Emotionally disturbed due to continuous friction in the home, marital discord, mentally ill parents

Exposed to unwholesome and demoralizing circumstances

Note: These guidelines are currently under revision. New guidelines are scheduled to appear in late 1976.

DEFINING EMOTIONAL NEGLECT

by Leila Whiting

Children Today 5(January-February 1976)

Under the Child Abuse Prevention and Treatment Act of 1974, the states must comply with certain conditions in order to receive grant money and funding of projects. Suspected child abuse must be reported—and also cases of suspected child neglect; the law must also grant immunity to those who report either one in good faith.

Maryland, like other states, is eager to be eligible for various federal funds to enhance its efforts in the area of prevention and treatment of child abuse and neglect. It is in the process of considering a bill which requires that child neglect be reported, and undoubtedly this will be passed in some form. The dilemma of determining whether or not a child is abused is difficult enough; to that will be added the dilemma of having to determine if a child is neglected. For the investigator the problem is a complex one, but what about the reporter? Generally, certain classes of professionals are designated as "must" reporters—how are they, then, to determine when they must report a child as neglected and, even more difficult, as emotionally neglected?

Most laws offer very limited help in arriving at such a determination. Maryland law defines a neglected child as one under the age of 18 years who is living in conditions "endangering his physical or mental well-being." Included in the Maryland State Department of Human Resources' guidelines to neglect are such items as: "Malnourished; ill-clad; dirty; without proper shelter or sleeping arrangements; lacking appropriate health care; unattended; without adequate supervision; ill and lacking essential medical care."

How such things as "proper" shelter, "appropriate" health care and "dirty" are defined varies from one community to another. Although these judgments are difficult enough to make, the guidelines go on to define an emotionally neglected child as one: "denied normal experiences that produce feelings of being loved, wanted, secure." The words are clear and explicit, and most of us have a "gut" response of knowing exactly what they mean. The problem lies in attempting to define them in a specific community in relation to a specific child. Of equal importance, then, is how to recognize when a child's behavior should arouse a suspicion of "emotional neglect." For example, what specific kinds of behavior should alert a classroom teacher or school counselor to suspect emotional neglect?

Montgomery County, Maryland, is an affluent suburb of metropolitan Washington, D.C. A recent census changed its category from "suburban" to "urban," although almost two-thirds of its area is rural. Its population of about 600,000 is predominantly middle-class. Three years ago the community was shaken by the death of a 9-year-old girl at the hands of her father and stepmother, and a Task Force on Child Abuse was created by the County Executive to develop specific recommendations in an attempt to prevent the recurrence of such a tragedy. The task force developed a community plan which included increasing health and social service staff to better cover receipt and investigation of reports of abuse and neglect; establishment of a multi-disciplinary, multi-agency child protection team; and creation of the position of a community child protection coordinator. The functions of the child protection coordinator include the mounting of educational efforts, at many different levels, to sensitize the community to problems of abuse and neglect. In a sense, the coordinator should be the community's "consciousness-raiser." Part of this job, then, is to see that the problems of child abuse and neglect achieve high visibility, that professionals and citizens in general are enlightened on the subject and that thinking and awareness of the problems are stimulated.

To help accomplish this, a 1-day seminar workshop was planned for June 1975, to be open to all those in the county who work with children in any setting. Its objective was to stimulate thinking and communication, and to see if we could get a little closer to a practical behavioral definition of what constitutes "emotional neglect" of children. The need to discuss and define the issues was apparent in the immediate response of those who pre-registered to attend the

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A Community Workshop Looks at Neglected Children

workshop. There were teachers and teacher aides; health room aides and school nurses; hospital registered nurses and County Council members. Social workers, psychologists and psychiatrists from the Health Department and public schools registered, as did homemakers and case aides, day care workers, lawyers, policemen and members of the clergy.

Two objectives were announced for the workshop: to provide those working with emotionally neglected children an opportunity to learn some new skills and to help participants develop new insights into the meaning of emotional neglect of children.

At one end of the spectrum of neglect is the kind relatively easy to recognize—that which closely resembles abuse because a child's physical well-being seems to be in immediate danger. At the other end are those children who live in families with life-styles different from those of the majority but into whose life society has, justifiably, no mandate to interfere. In between is the grey area, where special judgment must be exercised to identify those children who can be appropriately termed neglected. Our workshop addressed itself to attempting to clarify and define the concept of emotional neglect in relation to practical examples offered by those working with children in a wide variety of settings. At the same time, we wanted to offer practical suggestions for handling children who present behavioral difficulties. By inviting people who work with children in many different settings to attend the workshop, we also hoped to develop a bank of examples of "pieces of behavior" which could be used as an index of suspicion of emotional neglect.

The workshop, "Emotionally Neglected Children," was attended by 120 persons. James P. Gleason, the Montgomery County Executive, delivered the opening remarks, and keynote addresses were delivered by Bertram S. Brown, M.D., Director of the National Institute of Mental Health, and K. Patrick Okura, executive assistant to the Director. The large group of participants then broke into six smaller groups, each with a leader and two resource persons. The group leaders included a psychologist, a forensic child psychiatrist, a public health nurse, a professor of human development, an attorney and a social worker. Resource persons were drawn from the county Health Department's mental health clinics and the Department of Social Services.

The smaller workshop groups met in morning and afternoon sessions and then all joined for a final wrap-up discussion. A second all-day workshop, this one to discuss issues involved in dealing with emotionally neglected children, is planned for the spring. It too will be open to all who wish to attend.

The workshops generated a great deal of discussion and communication. They also stimulated thinking about a variety of aspects of child abuse and emotional neglect and resulted in case illustrations and a list of child behaviors considered to be danger signals.

Each of the workshops emphasized the possibility and danger of thinking that certain aspects of cultural or life-style differences might be misconstrued as emotional neglect. At the same time, the need for some community norms was emphasized. This concept of "cultural difference" also arises in other situations. Sometimes when a suspicion of child abuse is investigated and the child found to be, indeed,

abused, the family claims that in its native culture this so-called abuse is normal and acceptable "discipline" for children. Or family members may insist that children have been "disciplined" in this fashion for generations: that they had been treated in the same way and "turned out alright," and that, therefore, they are "correct" in treating their children in the same fashion.

Most communities insist, however, that families abide by their laws. A family from another culture which claims that whipping a child is proper discipline "at home" may find itself in violation of state child abuse laws. In situations involving abuse and neglect, furthermore, we must be suspicious of the use of "cultural differences" as an excuse, since most societies care for their young with love and tenderness, and deprivation and abuse are non-acceptable everywhere. But lifestyles can indeed differ, and so the child's total development and health—physical and psychological—need to be carefully evaluated on a case-by-case basis in order to determine whether a situation does indeed involve neglect.

The workshops generated discussion regarding situations which had puzzled participants. Most of the case examples were focused on family situations and concern about parental ineffectiveness, parental resistance to suggestions for professional help and parents' refusal to admit that their behavior was abusive or neglectful. Some examples include the following:

- Many elementary school-aged children are left unattended before and after school, during those hours between a parent's departure for and return from work. Obviously, it is neglect when no supervision has been provided by a parent for a young child through a sitter or day care facility. But how do you assess a situation to determine whether or not an older child is emotionally or physically neglected in such a case?
- A child runs away persistently. Even if the family appears to be non-abusive, it can be assumed that the child's needs are not met in some way. Is this emotional neglect?
- A mother refuses to take her child for an eye examination, although the child obviously has a vision problem. Should the teacher, who notices the child's behavior becoming more difficult to handle as he is less able to see the world around him clearly, report this as emotional or physical neglect?
- A child is absent from school about half the time; he is loud-spoken, foul-mouthed and belligerent when he is present. Is he neglected?
- A 15-year-old has an infant. She is needy and emotionally starved; so is the baby. In this instance, who is the neglected child? Or are they both neglected children?
- The child of an affluent family creates constant disturbance in school and shows definite signs of emotional problems. However, the family recognizes no difficulty and refuses referral for therapeutic help for the child. Is she neglected?

...neglect of children can only be viewed in the context of the total family situation.

- The child of another affluent family is retarded. Although provided with food, clothing and housing, he receives little attention at home and seems to be regressing in school. The family sees no problem but a teacher considers whether she should report him as neglected.

As these examples show, neglect of children can only be viewed in the context of the total family situation, and it always needs to be defined in terms of something a parent is doing —by acts of commission or omission. Two of the workshops arrived at a beginning definition of emotional neglect. The first defined it this way:

"Emotional neglect is a result of subtle or blatant acts of omission or commission experienced by the child which causes handicapping stress on the child and is manifested in patterns of inappropriate behavior. Court intervention may be applicable if a parent fails to recognize the need for or accept help or change."

The second definition reads:

"Inability of meaningful adults to provide necessary nurturance, stimulation, encouragement and protection to the child at various stages of development which inhibits his optimal functioning."

Both of these definitions emphasize the child's functioning. One talks of "handicapping stress" resulting in "inappropriate behavior," thus addressing both the internal structure of the child and the resulting symptoms. The other mentions inhibition of "optimal functioning." Both recognize parents as curative or causative agents, thus placing the problem in a family context, where it, indeed, belongs.

It is interesting to compare these definitions to that in an American Humane Association publication:[1]

"Like moral neglect, emotional neglect is an intangible. The consequences of emotional neglect, however, may be, and often are, observable in the child's behavior and conduct. A child may be said to be emotionally neglected when there is failure on the part of the parents to provide him with the emotional support necessary for the development of a sound personality. A child may become emotionally neglected when the climate in the home lacks the warmth and security essential for building in the child a sense of being loved and wanted. When attitudes in the home are tense, hostile, unfriendly or threatening; when a child is met with overt or subtle rejection; when by direct or open statement, or through less defined, but equally meaningful implications, he is made to feel unwanted; when he is made to feel he does not belong; when he is 'picked upon' or is the butt of frequent blame or ridicule; and when, subtly or openly, he is made to feel inferior to others, we have a home climate which inevitably will produce an emotionally neglected child. These elements, singly or in combination, may be the root cause for evolving a confused or emotionally disturbed child."

The emphasis here is clearly on the

climate in which the child lives, and to which he reacts. One might find cause to argue with such concepts as "sound personality," "attitudes in the home" and "inevitably will produce," but in thinking about the issue it becomes clear that it is the interaction between the child and his total environment that gives rise to a situation in which it can be said: "This is an emotionally neglected child." What is not clear is how this concept differs when applied to an emotionally disturbed child; however one defines "emotionally disturbed," also a difficult and problem-filled task.

The difficulty in differentiating between "emotional neglect" and "emotional disturbance" was highlighted in the list of examples offered in one of the workshops. It may indeed be that we are discussing the same thing, and that by placing a different label on the condition, we may stimulate help and services for the child and family. That is, by labeling it "neglect" the condition becomes reportable and thus visible to a section of society that has the power to actively protect children and to invoke court authority when all other efforts to help fail.

The list of behaviors generated by the workshop ran the gamut from failure-to-thrive to teenage pregnancy. Behaviors which raised the index of suspicion and alertness in those dealing with the child were discussed, and when a few of the behaviors were seen together to form a pattern, and were coupled with persistence, participants agreed that a strong suspicion of emotional neglect was justified. The list of behaviors was the same as may be found in any book of child psychopathology—hostile aggression, enuresis, encopresis, fire-setting, sadistic behavior, poor peer relationships, persistent under-achieving, truancy, immaturity, etc.

The question which immediately comes to mind, then, is how does a diagnosis of emotional neglect differ from that of emotional disturbance? After all the discussion, emotional disturbance seemed to be what we were describing, and we had thought we had gathered together to discuss emotional neglect. However, it can be said with some degree of certainty that a child who persistently exhibits several of these symptoms is one who has family problems which need some kind of intervention, if the child's psychological and emotional growth is not to be permanently stunted. Could it be, then, that emotional neglect arises when the family refuses to attempt to ameliorate a situation?

A community workshop focused on identifying how to recognize emotionally neglected children found itself discussing emotionally disturbed children.

In order to determine emotional neglect, therefore, the total situation must be evaluated. The child's "symptoms" or behavior will arouse suspicion, but there will have to be a necessary assessment of his total environment in order to decide what to do and how to do it. Those responsible for the child (usually parents) need to be involved and their response, awareness and willingness to take appropriate action may make the difference between a diagnosis of *emotional disturbance* or *emotional neglect*. That is, the child may be presenting himself in such a way, with such a combination of behaviors, that those working with him become convinced that he is showing signs of "less than optimal functioning," or a pattern of "inappropriate behavior" indicating internal stress. Something is evidently not "right." The caretakers' response may be, then, what differentiates between emotional neglect and emotional disturbance. If the caretakers (parents) indicate their concern and demonstrate a willingness and ability to carry through and seek appropriate help, to effect some change in the total environmental situation of which they are an integral part, then, perhaps, one can say that this is a case of "emotional disturbance."

If, on the other hand, the parents or caretakers are reluctant to acknowledge a problem, resist seeking appropriate help, refuse to take any action to change the child's total situation (of which they are an integral part), then, perhaps, one can say this is a case of "emotional neglect." The conscious and unconscious reasons for a caretaker's refusal to engage in remedial action may be important for those working with the family, since this knowledge would affect techniques in dealing with them, but it would not affect the decision that the child was or was not emotionally neglected.

It is at this point that the legal issue of emotional neglect may arise, when, having exhausted other avenues of attempting to ameliorate the child's high-risk situation, the one working with the child decides that this is reportable emotional neglect. It is up to state legislatures to define this in such terms that those mandated to investigate and take action have some clear guidelines against which to measure and assess the total situation. Judges also must have a law against which they can judge the claims and counterclaims that a child has or has not been emotionally neglected.

Summary

A community workshop focused on identifying how to recognize emotionally neglected children found itself discussing emotionally disturbed children. As a result, the complex issues involved in defining *emotional disturbance* and *emotional neglect* may be resolved in terms of parental response to the identification of the problems. The child is emotionally disturbed; parental response determines whether or not the situation becomes one of emotional neglect. Perhaps more definitively stated, emotional neglect of a child equals the parents' refusal to recognize and take action to ameliorate a child's identified emotional disturbance. ■

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[1] *Protecting the Child Victim of Sex Crimes Committed by Adults*, Vincent DeFrancis, American Humane Association, P.O. Box 1266, Denver, Colorado 80201.

Preparing for a Neglect Proceeding: A Guide for the Social Worker

By Cynthia Bell and Wallace J. Mlyniec

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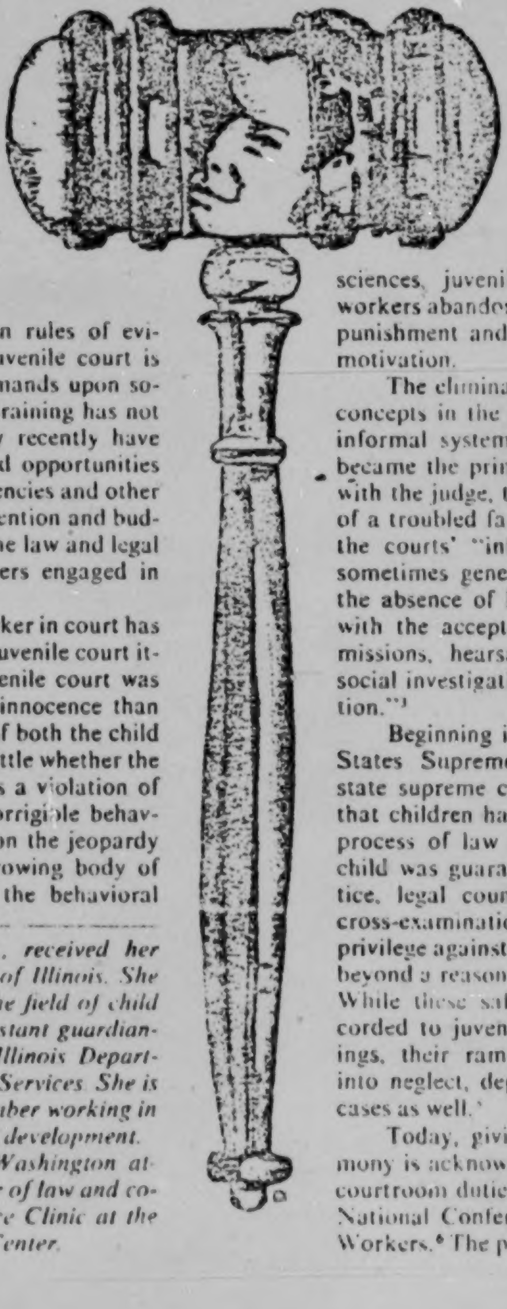

Background

The greater emphasis on rules of evidence and on facts in the juvenile court is making new performance demands upon social workers for which their training has not wholly prepared them.[1] Only recently have schools of social work offered opportunities for legal training and have agencies and other service bodies turned their attention and budgets to in-service training in the law and legal consultation for social workers engaged in child protection work.

The role of the social worker in court has followed the evolution of the juvenile court itself. At its inception, the juvenile court was less concerned with guilt or innocence than with the ultimate well-being of both the child and the society.[2] It mattered little whether the cause of the court action was a violation of law, parental neglect, or incorrigible behavior; the proceedings focused on the jeopardy of the child. Utilizing the growing body of knowledge emanating from the behavioral sciences, juvenile court judges and social workers abandoned the concepts of crime and punishment and concentrated on behavioral motivation.

The elimination of traditional adversary concepts in the juvenile court resulted in an informal system whereby the social worker became the prime figure striving, in concert with the judge, to alter the behavior patterns of a troubled family. As Jacob Isaacs put it, the courts' "informality of procedure was sometimes generally equated not only with the absence of legal representation but also with the acceptance of uncorroborated admissions, hearsay testimony, and untested social investigation as the basis for adjudication."[3]

Beginning in 1966, however, the United States Supreme Court, and subsequently state supreme courts as well, acknowledged that children have the right to the same due process of law accorded adults.[4] Thus, the child was guaranteed the rights to prior notice, legal counsel, and confrontation and cross-examination of sworn witnesses; the privilege against self-incrimination; and proof beyond a reasonable doubt before conviction. While these safeguards were originally accorded to juveniles in delinquency proceedings, their ramifications have carried over into neglect, dependency, and incorrigibility cases as well.[5]

Today, giving substantive factual testimony is acknowledged as one of the primary courtroom duties of the social worker by the National Conference of Lawyers and Social Workers.[6] The participation of social workers

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is more significant in juvenile and family courts than in other courts where their function is still limited to social investigation.[7] While social workers continue to have "an expertise that enables them to assess the danger in particular circumstances" and thereby formulate a "social diagnosis," that diagnosis is now considered a "source of evidence" in juvenile and family courts and is subject to admissibility tests in courts.[8]

Problems in Court

The growing emphasis on strict application of the rules of evidence and a tendency to adversary proceedings in the juvenile courts has resulted in changed judicial expectations of social workers. Social workers attempting to gain legal knowledge and cope with its requirements under judicial scrutiny are often responding with frustration and distrust. Judge Patrick Tamilia has observed that when social workers are confronted in the adversary process their "reaction is one of affront and personal injury . . . they tend to become polarized in the belief that they are the protectors of the children against legal charlatanism."[9]

This distrust of the legal profession by social workers is usually met with a similar distrust by lawyers of the social work profession. For example, attorney Richard Levine writes, "It is reasonable to assume that the misperceptions of the caseworker will permeate and determination of parental neglect . . . . It is accurate to say that 'casework is really not scientific at all in the sense that it makes a relentless unbiased examination of all the facts but rests on an *a priori* system of values . . . . With this wilderness of unarticulated values, perhaps the touchstone of neglect is not poverty, but the caprice of the caseworker' . . . ."[10] Further, Jacob Isaacs, another attorney, writes, "Social workers, like all humans, are sometimes prone to incompetence, laziness, and even bias, and it is the duty of counsel to guard his client against the consequences of such inadequacies."[11] Such broad statements reveal prejudgments with which social workers must cope in developing working relationships with their colleagues in other professions.

Lack of clarity regarding terminology may also exacerbate the difficulties faced by the social worker in dealing with court cases. Attorney William T. Downs studied social work literature and found it alluding to two types of neglect: social neglect, and legal (statutory) neglect. However, he rejected this distinction and substituted "suspected neglect" for "social neglect," saying that social neglect is something that "social workers cannot communicate or describe to the court."[12] While this inability to communicate can be the fault of either the speaker or the listener, it suggests the possibility that social workers are sometimes unable to prove neglect in court because they fail to operate from the same definition of neglect as the court. In practice, varying definitions of neglect may obtain within a single jurisdiction because of the nonspecificity of neglect statutes, the absence of clarifying case law, and the various concepts of proper care possessed by the judges of the court.

Mutual prejudice and distrust between the legal and social work professions, as well as confusion in terminology, are important barriers to effective courtroom presentation. It is in the area of compiling and presenting factual material, however, that social workers experience the greatest difficulty and receive the most criticism.[13] Since the social worker is often the only person who has had firsthand observations of the endangered child's care, the worker's presentation of that data is of critical importance. It is at the adjudicatory proceeding that the court determines whether the allegations of the neglect petition are supported generally by a preponderance of the evidence.[14] Absent a finding of neglect, the court will dismiss the petition.

An example of failure to use facts in conjunction with the statute concerns a nine-year-old girl who was living in a motel with her mother who was recovering from cancer surgery. The girl was not attending school or having an opportunity to be with her peers. The Court of Appeals reversed the adjudication and said:

> Our review of the record convinces us that the sum and substance of the evidence in support of the petition reflects nothing more than an opinion of what an ideal home atmosphere *should* consist of, rather than a showing that *this* child's well-being was being endangered. Nor do we find sufficient evidentiary support for a finding of neglect.[15]

In another case, two child welfare workers who had had limited contact with the young mother of an infant testified that they did not believe she would be a fit and proper parent. Since the young mother had not had actual custody of her child and since the petition did not claim she failed to insure proper care, the appellate court found that neglect as defined by the statute was not shown. The court held that the workers' testimony was speculative as to the future care of the child.[16]

Judge Tamilia has summarized the ultimate effect upon child welfare services of withholding legal counsel and evidentiary assistance from social workers: "The real danger is that if presentations are not adequate or the court, in the absence of counsel for the agency, does not to some degree assist or direct the caseworker in obtaining and presenting the available evidence, the agency and community programs designed to protect children can be seriously demoralized and limited to offering service only when the client is willing to accept it."[17]

Social workers will find the limited but growing case law in neglect and abuse instructive in their ongoing efforts to maximize their effectiveness in court. A review of this body of material reveals that some social workers have difficulty distinguishing facts from personal opinion and speculation; in addition, there may be reliance on hearsay evidence; poor record-keeping; and inadequate presentation techniques. From the reported cases and from experience, it appears that social workers need to strengthen their work in three areas: (a) collection, preservation, and analysis of factual data for court testimony; (b) management of second-hand information and hearsay testimony; and (c) participation in pretrial conferences with the county attorney.[18]

Making a Record

Building a legally-usable record of facts for possible litigation begins *at intake* in all cases of suspected child abuse or neglect. Regardless of how receptive to services and workable a parent or guardian may appear, every protective service case has a potential for court action. For it is through such action that the ultimate protection of an endangered child lies.

While a social worker should follow the practice of exploring all nonjudicial resolutions of neglect, such exploration does not obviate the value of laying a foundation of fact in each family case file from which to build an effective case in court should judicial action become necessary. Indeed, the very records kept can be used to make a determination of whether or not to go to court. Accurate, complete summaries of parental functioning, over time, can show or fail to show child-care improvement. In the area of neglect the pattern of conduct is considered, rather than one action or omission.

Once the social worker has made the decision to go to court, the protective service records will have various uses. In order for the judicial proceeding to be initiated, the county attorney must file a petition or pleading with the court setting forth the allegations, which, if proven true, will give the court jurisdiction over the child. Failure to prove the allegations will result in a finding that the child is not neglected. It is essential both for the protection of the child and to accord due process to the parent that the petition accurately reflect the facts which the government will seek to prove. Since the worker will most often be the supplier of the information, an accurate case record will insure a valid petition.

Once the case has been formally initiated in court, the primary value of the protective service record is to refresh the worker's memory so that testimony can be prepared for court. Social work records are not generally admissible at trial.[19] Since many cases have long histories before court action, and since case loads are usually high, it is unrealistic to assume that a worker can remember all that has transpired. Also, in cases where termination of parental rights is being sought long after the original neglect finding, prior workers may no longer be associated with the case. If their testimony is essential to a ruling of termination, accurate records will be indispensable for refreshing their memory.

The worker must assume that these records will be discoverable by all the attorneys in the case.[20] The worker who keeps unbiased, well-documented records has no reason to be apprehensive about discovery. However, if the records are inaccurate, or unverified, or contain unsupportable conclusions, the worker can expect a vigorous and damaging cross-examination by the parent's attorney.

Social work recording has traditionally been geared to meeting administrative, supervisory, teaching, and research requirements. But "too often, records have not been consistent or full enough to allow retrospective observations about effectiveness or even to permit factual statements about what the social worker did."[21] Recording has focused upon social history, worker-client feelings, and diagnosis without documentation of what the social worker and the client heard, saw, said, and did to support the resultant diagnosis and subsequent treatment plan. It has been further noted that the casework record has received little attention, except for its deficiencies, in the professional literature.[22]

The tasks, responsibility, authority, and accountability of the social worker in protective services warrant a recording format which preserves and organizes factual data and which also meets supervisory and other professional requirements. A workable, multipurpose recording format for protective service social workers is composed of four modes: (1) case notes; (2) statutory chart; (3) compilation of exhibits; (4) casework recording. The latter mode draws upon the first three in formulating an ongoing work plan.

Case notes. Beginning at the point of intake, informal notetaking immediately after each client or collateral contact (interview, home visit, telephone call, etc.) is critical while the memory is fresh. These notes can be an important repository of significant quotations, observed inconsistencies,

and ideas for future interviews, as well as for the preparation of court testimony.

Written memoranda in sufficient detail and quantified terms can cover but are not limited to the following vital areas:

- The client's response upon being confronted with a neglect complaint;[23]
- The client's acceptance of and reaction to protective services;
- The client's record regarding the keeping of appointments;
- The social worker's explanations to the client of obligations and rights regarding visits, support, and other demonstrations of parental interest;[24]
- Efforts on the part of the social worker to reunite the family;
- The identity and whereabouts of the natural father of the child; attempts to contact him;[25]
- The client's explanation of the child's injury;
- Witnesses who can testify about the injury or accident; proper and up-to-date addresses and telephone numbers of all witnesses;
- The client's facial expression, mannerisms, and physical activity in crucial discussions;
- The physical appearance and verbalizations of the child;
- The people present at the interview;
- The time period during which the infant was left unattended;
- The physical manifestations of the child's failure to receive proper parental care;
- The condition and appropriateness of the clothing;
- For any event: when, where, who, how long, what time, how many?

In short, all kinds of observable information should be recorded precisely. If impressions are recorded, they should clearly be labelled as such and be founded upon observable information. While this may seem burdensome at the moment, it will prove to be invaluable later. Failure to keep "hard" (specific) facts available in case notes and other recordings can prevent proper preparation for court. Lacking adequate detail and case examples, a social worker may be forced to make conclusions out of sparse factual information. Such action by a social worker in *Patton* v. *Armstrong* led the appellate court to find "the tenor of the report shows a lack of trust for the court by indicating, by inference, that he (the court) would be unable to judge the facts."[26] Such conclusionary reports and testimony will result in strained social work-law relationships and the exclusion from evidence of the very facts which may protect a child

FIGURE 1

Worker
Agency Goal:
Guardianship ☐ Temporary Custody ☐ Termination ☐

Parent Address

Parent Address

Other Address

Section 2-4: Neglected Minor (Under 18 years)	Child	Facts and Dat[illegible]	Witness(es), Address(es) and Date(s)	Social Worker Observation(s) and Date(s)
(a) Who is neglected as to proper or necessary support				
Who is neglected as to education as required by law				
Who is neglected as to medical or other remedial care recognized under state law or other care necessary for well-being				
Who is abandoned by parents, guardian, or custodian				
(b) Whose environment is injurious to his welfare or whose behavior is injurious to his own welfare or that of others				

Source: Illinois Revised Statutes 1973, Chap. 37 §702.4 used for illustrative purposes only. Chart conceptualized by Harry Krause.

Statutory chart recording. The use of a statutory chart facilitates the juxtaposition of observed parental behavior with a given state's pertinent neglect and unfitness statutes. Use of this recording method can serve to increase worker familiarity with statutory language and enable the logical ordering of facts for worker planning and study. At least one appellate court has indicated the need for improvement in this area. "One cannot accept the social worker's definition of abandonment as 'not seeking psychiatric help in trying to remedy the situation in her home. . . .' Sociological theory and definitions cannot be used to dilute the strict language of the statute."[27]

Figure 1 illustrates a proposed recording format whereby the child's name, observed fact, date, witness's name and address, and social worker's name are listed in relation to the statutory categories of neglect. Using this format, a worker can translate parental actions and inactions that adversely affect a child into possible violations of state statute.

To develop skill in recognizing and describing neglect, a worker will find the checklist (figure 2) entitled Identifying Conditions of Child Neglect to be a useful tool.[28] The checklist consists of operational descriptions of neglectful or abusive parental care or children's conditions or behaviors resulting therefrom. These conditions and behavioral patterns of the parents and child, when observed and documented, can be recorded in the statutory charts shown in figure 1.

Figure 2

Identifying Conditions of Child Neglect

Physical

1. Physically abused
2. Sexually abused
3. Exploited
   - A. Excessive responsibilities placed on very young children to care for home and other younger children
   - B. Overworked beyond physical endurance
   - C. Forced to beg and steal
   - D. Forced to sell commodities beyond child's ability to do so
4. Malnourished and emaciated
5. Failure to receive necessary immunizations
6. Suffers chronic illness and lacks essential medical care
7. Lack dental care
8. Failure to receive necessary prosthetics, including eye glasses, hearing aids, etc.
9. Failure to receive proper hygiene
   - A. Unwashed
   - B. Unbathed
   - C. Poor mouth and skin care
10. Failure to attend school regularly due to the faults of the parent
11. Without supervision
12. Left alone for hours and days
13. Abandoned

Emotional

1. Denied normal experiences that produce feelings of being loved, wanted, secure, and worthy
2. Rejected through indifference
3. Rejected overtly—left alone, shouted at, blamed for problems, etc.
4. Emotional neglect is intangible, but the child's behavior often reveals visible symptoms such as hyperactivity, withdrawal, overeating, fire setting, nervous skin disorders, psychosomatic complaints, autism, suicide attempts, truancy, delinquencies, failure to thrive, aggressiveness, discipline problems, stuttering, enuresis, hypochondriasis, and overprotection.

Material

1. Insufficient clothing
   - A. Fails to keep child warm and comfortable at home, at school, and at play
   - B. Seriously fails to protect the child from the elements of the weather
2. Improper clothing
   - A. Dirty, smelly, ragged, and generally in terrible disrepair
   - B. Wearing of such clothing usually results in ridicule and harassment from the child's peers.
3. Filthy living conditions
   - A. Garbage and dirt strewn about the house and yard
   - B. Floor and walls smeared with crusted feces
   - C. Urine smell permeates throughout the house
   - D. Vermin
   - E. Soiled bedding and chairs
   - F. Home conditions in total chaos—no evidence of routine housekeeping.
4. Inadequate shelter
   - A. Cold
   - B. Overcrowded
   - C. Makeshift sleeping arrangements
   - D. Poor lighting
   - E. Poor ventilation
   - F. Fire hazards
   - G. Poor sanitation as a result of inadequate or unrepaired plumbing
   - H. Other hazardous conditions existing for children such as broken stairs, broken windows, broken porch and stair railings, etc.
5. Insufficient food
6. Haphazard meals
   - A. Meals which consistently lack nutritional value
   - B. Steady diet of potato chips, pop, candy, peanut butter, crackers, etc.

Demoralizing Circumstances

1. Continuous friction in the home
2. Mentally ill parents
3. Marital discord

4. Immature parents
5. Excessive drinking
6. Addiction to drugs
7. Criminal environment
8. Illicit sex relations
9. Overly severe control and discipline
10. Encouraging delinquencies
11. Mental retardation of parents
12. Harsh and improper language
13. Nonsupport
14. Values in the home in conflict with society
15. Failures to inculcate value system in guidance and care of children (lack of moral training)
16. Broken home, divorce, and frequent remarriages
17. Failure to offer motivation and stimulation toward learning and receiving an education in keeping with child's ability and intelligence
18. Failure to provide healthy, wholesome recreation for family and children
19. Failure to individualize children and their needs
20. Failure to give constructive discipline for the child's proper development of good character, conduct, and habits
21. Failure to give good adult example
22. Promiscuity and prostitution.

Compilation of exhibits. In the process of working with a family, numerous kinds of official documents or records will be encountered. Aside from the recollection-refreshing aspect of these documents, many can be independently admitted into evidence. Those that are inadmissible can provide a record of witnesses such as psychologists, who will have to be called to attest to their findings and in some cases, their conclusions. Consequently, the material should be preserved in the file. Some more frequently used documents are birth, death, and marriage certificates; school attendance and achievement records; and child abuse and other medical records. Some of these records are public and may be obtained without authorization of the client. When such records are obtained, the copies should be duly certified as true copies of the original. If the records are not public, authorization from the client must first be obtained. These copies should also be certified.

Certainly copies of all applications or contracts and agreements associated with the case must be preserved as well as copies of all letters sent to all persons having interest in the case and all correspondence received. All of this material should be preserved in a manner whereby it can quickly be located.

If the office is divided into separate branches, such as foster care, family worker, and adoption, all of which preserve their own files, methods should be devised for cross referencing so that all pertinent information can be retrieved without difficulty.

If photographs have been taken in abuse cases, these should be preserved along with notations regarding when and where the photo was taken, who the photo depicts, and who the photographer was.

Casework recording. By systematically reviewing case notes, the statutory chart, and exhibits, the worker has information from which diagnosis, planning, and action are undertaken in providing protective services to families. A careful synthesis of the gathered information at planned intervals allows ongoing problem identification, objectives-setting, and planned social work intervention.

Any number of recording formats may lend themselves to protective services requisites. The Problem-Oriented Record (POR), among others, would have applicability.[29] Crucial recorded information under any format will allow assessment of changes in the condition and behavior of the child and parent over time and will recount the social worker's activity, client activity, social worker-client interaction, and mutual objectives. Also essential in recording is information regarding how the agency became involved with the family, why the agency is presently involved, and the rationale for major intervention, e.g., foster placement, legal action, and, finally, short- and long-term goals for the family. Casework recording can be used for assessing parental functioning and social work intervention. Objectives and social worker activity can be tested and modified as necessary. When an objective has been set to initiate court action, the worker can draw upon the case recording to prepare a petition or court report and to refresh his memory for court testimony.

In preparation for the pretrial conference with the county attorney, the worker should review the currency and relevancy of the information in the record. Determining the facts about which the worker has first-hand knowledge is essential. All pertinent data should be distilled into what the worker saw and heard. Observations should be quantified. Only facts which the worker can document and which would persuade the reasonable person of serious neglect should be used.

Managing Second-Hand Information

Determining what is hearsay testimony and when technical hearsay should be admitted as an exception to the general rule of nonadmissibility has troubled judges and lawyers for many years. It is no wonder that social workers find themselves confused when trying to understand it. Hearsay evidence is defined as "testimony in court, or written evidence, of a statement made out of court, the statement being offered as an assertion to show the truth of the matters asserted therein, and thus resting for its value upon the credibility of the out-of-court asserter."[30] Loosely translated, it means that a statement made outside of the hearing cannot be placed in evidence because there is no opportunity to test its reliability through the cross-examination of the person who made it. A second courtroom requirement often associated with hearsay is that a witness must have first-hand knowledge of the facts about which he is testifying.

A general rule regarding courtroom testimony is that unless a worker saw or participated in the activity about which he is testifying, the testimony will be inadmissible. Similarly, if an out-of-court statement by a parent or a child is to be admitted, the person to whom the statement was made must testify about it.[31] Social workers can maximize their opportunities for gaining first-hand knowledge by personally confirming observations reported by others.

Social reports usually lend themselves to hearsay objections since they contain a considerable amount of information received from third parties. Since the third party is not available to have his credibility tested by cross-examination, the reports will be excluded at trial.[32] Some records, such as medical reports, may be admissible under a local business records act, the rationale being that records kept in the normal course of business will be reliable and their contents will be probative.[33] The same is sometimes true of psychiatric records,[34] although such information may be excluded on the grounds that psychiatric and psychological opinions are subject to varying interpretations.[35] This prohibition may also apply to social work case records and court reports.[36] Although the county attorney will usually be more capable than the worker of determining what evidence is admissible, proper preparation by the worker will make the lawyer's job easier.

As the worker gathers information about a family, he should carefully note whether the facts are those which he has observed himself or whether they were seen by other people. If another person is the source of the information, accurate data regarding the name and address of the person should be kept in the file for future use. Since a worker cannot testify about what other people saw or told him, the sources of the information will have to testify in court. Often workers believe that they can testify about what previous caseworkers had witnessed. This is not true. If new workers are assigned to the case, the prior worker may still have to testify to complete the factual presentation.

Pretrial Conferences

No competent attorney ever takes a case to trial without first preparing witnesses. Neglect trials are no exception. Unfortunately, many county attorneys are plagued by high caseloads and cannot always prepare a case as well as they should. However, if the worker has kept a complete, accurate case file, pretrial conferences will be productive.

Conferences will be necessary prior to petitioning the case, as well as prior to trial once the case has been petitioned. At the petitioning conference, the worker should be prepared to tell the county attorney which sections of the neglect statute are alleged to have been breached; how they have been breached; who will provide the initial information showing the breach; the status and location of the child; a brief summary of what efforts have been made to preserve the family unit; and why court action is now necessary. It is not essential that the case be proved at an initial hearing. However, there must be sufficient evidence adduced to convince the court that action must be taken to protect the welfare of the child until a full hearing is held.

The conferences prior to trial will be much more detailed. The worker should be prepared to advise the county attorney who the necessary witnesses are, what each will say, and how credible their testimony will be. If there are flaws in the story of a potential witness, if bias is present, or if the witness is frightened, or is potentially unavailable, the county attorney must be apprised of it. Each witness must be approached differently. If the county attorney is aware of potential problems with a witness, his preparation will be better.

If the worker is to be a witness, he must prepare for both direct and cross-examination. Since the credibility of a witness is enhanced by his qualifications and experience, the worker should prepare and make available to the county attorney a biographical sketch which includes information regarding training and practical experience. Degrees, publications, awards, and positions of supervisory capacity should be noted.[17] Often workers become defensive when asked for this information. It must be remembered that the information is solicited not for the purpose of embarrassing or second-guessing the worker, but merely to strengthen the case. The worker's testimony, like the testimony of all witnesses, should be stringently evaluated for flaws. Information must be current and first-hand. Potential bias and contradictory statements must be discovered and anticipated prior to cross-examination. Lapses in memory must be accounted for.

The delivery of testimony must also be prepared. It should be gone over several times to ensure that nothing is forgotten. Simulated direct examination should be attempted. Generally, answers to questions should be concise, precise, responsive, and devoid of jargon, conclusions, and opinions. The ultimate finding of neglect should be based on facts, not feelings. Although a worker's case notes may be used to refresh his memory, testimony given without extensive referrals will be more credible. The time to refresh one's memory is prior to trial and not on the witness stand.

The worker who is to testify must also be prepared for cross-examination. A simulated cross-examination conducted by the county attorney prior to trial can be very helpful. Generally, answers must be responsive even if they are damaging. Bias, inconsistent statements, and errors or omissions of the worker are sure to be the subject of cross-examination. Nevertheless, the worker must avoid arguing with the parent's attorney. Badgering can usually be prevented by a timely objection by the county attorney, but tough questions must be answered. Anticipation of these problems, and proper preparation in pretrial conferences can usually defuse an otherwise explosive situation.

Since the evidence will usually include documentary as well as testimonial material, the worker should produce all potentially useful documents or other exhibits at the conference so that the county attorney can determine which are necessary. Production at the conference will help avoid admissibility problems at the trial.

Finally, the worker will often be aware of the possible defense that could be raised in a case by the parent. Since the county attorney must meet these defenses by cross-examining witnesses for the parents as well as by the presentation of rebuttal evidence, any assistance the worker can provide will be important.

It is essential that workers be absolutely candid with the county attorney and with the attorney for the child in those jurisdictions where they are permitted. Few things are more uncomfortable for an attorney than being surprised at trial. A well-prepared worker can obviate the possibility of surprise. Certainly, disagreements between the county attorney and the worker may arise. But since their goal is the same, these problems must be resolved. The conference, and not the trial, is the place for their resolution.

New Directions

The increased provision and accessibility of training and knowledge in juvenile and family law to child welfare workers is imperative. Knowledge and skills in juvenile law and trial procedures would complement the training in psychology and human relationships which many child welfare workers have.

Greater cooperation between the county attorney's office and the social work agency must also occur. Since both agencies are dedicated to ensuring that children are protected, there is no reason for them to operate independently from or at cross purposes with each other.

Notes and References

1. The term social worker in this paper is used to denote those who engage in child protection work and includes but is not limited to child welfare worker and caseworker.

2. Julian Mack, "The Juvenile Court," *Harvard Law Review* 23 (1909): 104, 119–120.

3. For a fuller history of the juvenile court, see Jacob L. Isaacs, "The Role of the Lawyer in Representing Minors in the New Family Court," *Buffalo Law Review* 12 (1963): 501, 503.

4. *Kent v. United States*, 383 U.S. 541 (1966); *In re Gault*, 387 U.S. 1 (1966), *In re Winship*, 397 U.S. 358 (1970); *McKeiver v. Pennsylvania*, 403 U.S. 528 (1971).

5. See, for example, *In re B.*, 30 N.Y.2d 352, 282 N.E.2d 288 (1972).

6. The National Conference of Lawyers and Social Workers, *Law and Social Work* (Washington, D.C.: National Association of Social Workers, 1973), p. 32.

7. The National Conference of Lawyers and Social Workers, "Lawyer-Social Worker Relationships in the Family Court Intake Process," Publication no. 4 (1967): 4.

8. Kimberly B. Cheney, "Safeguarding Legal Rights in Providing Protective Services," *Children* 13 (May-June, 1966): 89.

9. Patrick Tamilia, "Neglect Proceedings and the Conflict Between Law and Social Work," *Duquesne Law Review* 9 (1971): 585.

10. Richard Steven Levine, "Caveat Parens: A Demystification of the Child Protection System," *University of Pittsburgh Law Review* 35 (1973): 17 citing Keith-Lucas, *Decisions About People in Need: A Study of Administrative Responses in Public Welfare* (1957) and "Child Welfare Services of Allegheny County," *Allegheny Manual* (unpaginated, 1972).

11. Isaacs, "The Role of the Lawyer," p. 516.

12. William T. Downs, "The Meaning and Handling of Child Neglect—A Legal View," *Child Welfare* (March, 1963): 131.

13. Harry Krause, Professor of Law, University of Illinois, Consultant to Department of Children and Family Services, State of Illinois, Legal Consultation Manual compiled by Cynthia Bell (unpublished, 1972).

14. E.g., D.C. Code 16-2317(b)(2). Cases in which termination of parental rights is sought may require the higher standard of clear and convincing evidence. *Huey* v. *Lente*, 85 N.M. 597, 514 P.2d 1093 (1973).

15. *In re Pima County Juvenile Action*, 18 Ariz.App. 219, 501 P.2d 395 (1972).

16. *In re Nyce*, 131 Ill.App. 481, 268 N.E.2d 233 (1971).

17. Tamilia, "Neglect Proceedings," p. 585.

18. The county attorney will be used throughout this article to indicate the government attorney designated by the local statute to try cases arising under the neglect code.

19. See *Patton* v. *Armstrong*, 6 Ill.App.2d 991, 286 N.E.2d 351 (1972).

20. *In re S.M.W.*, 485 S.W.2d 158 (Mo.Ct.App. 1972).

21. Rosalie A. Kane, "Look to the Record," *Social Work* 19, no. 4 (July 1974):412.

22. Ibid., 413.

23. The out-of-court statements of parties to the action are admitted as exceptions to the hearsay rule.

24. In *C.S. v. Smith*, 483 S.W.2d 790 (Mo.Ct.App. 1972). The court ruled that the agency (usually represented by a social worker) or a juvenile officer must establish that the "natural parents were fully aware of their right to visit their children and of their obligation to furnish support and other incidentals which demonstrate their interest in the children" before termination of parental rights could be ordered when the proceedings were based on willful neglect and abandonment. *Accord S.L.K. v. Smith*, 480 S.W.2d 119 (Mo.App. 1972).

In re Deerwester, 131 Ill.App. 952, 267 N.E.2d 505 (1971). The court found that the mother did not fail to maintain a reasonable degree of interest regarding the child's welfare since she "made periodic inquiries to and appointments with child's caseworkers and made plans to visit the child, which plans were not carried out because of difficulties in arranging with caseworkers for visits and by mother's lack of transportation."

25. *Stanley v. Illinois*, 405 U.S. 645 (1972) requires that putative fathers be given an opportunity to be heard regarding fitness.

26. *Patton, supra* at 353.

27. *In re M.J.M.*, 483 S.W.2d 795 (Mo.Ct.App. 1972).

28. The American Humane Association, "Identifying Conditions of Child Neglect" (training workshop, undated and unpaginated). Used with Association permission.

29. Kane, "Look to the Record."

30. McCormick, *Evidence*, 2nd ed. (West Publishing Co., 1972).

31. See note 24, *In re Deerwester*.

32. *In re Involuntary Termination of Parental Rights*, 449 Pa. 543, 297 A.2d 117 (1972). Court reports may be admitted at dispositional hearings, e.g., D.C. Code 16-2319 and review hearings. *In re Raymond G.*, ____ Cal.App. 3d ____, 110 Cal.Rptr. 81 (1973).

33. E.g., 28 U.S.C. 1732.

34. *Harter v. Iowa*, 260 Ia. 605, 149 N.W.2d 827 (1967).

35. *New York Life Insurance Co. v. Taylor*, 79 U.S.App.D.C. 66, 147 F.2d 297 (1945).

36. *In re Involuntary Termination*.

37. It would be helpful to qualify workers as experts so that they may testify regarding conclusions as well as facts. This point is made by Rowine Brown, Elaine Fox, and Elizabeth Hubbard in "Medical and Legal Aspects of the Battered Child Syndrome," *Chicago—Kent Review* 50 (1973), 45–76:

> [W]orkers have had special training in tactful interviewing and are apt to elicit information of extreme importance for the hearing. They are also trained in the observation of people and their reactions. The social worker may readily perceive when the parent, maintaining a defensive or hostile attitude, is fabricating, and further, the social worker may have observed the attitude of the parent to the child.

V. THE PROBLEM OF CHILD MALTREATMENT (V.10)

The Problem of the Battered Child

by
Gloria Belgrad

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Editor's note: Although child abuse can hardly be considered a new socio-legal phenomenon, the apparent magnitude of the problem and an increasing public awareness of its existence prompted the editors of the FORUM to include "The Battered Child" in this issue. It becomes quite obvious from the article which follows that more than mere judicial or legislative efforts will be necessary to even begin to deal with the complexities involved. Mrs. Belgrad, whose interest in this topic began while participating in a Legal Medicine Seminar at the University of Maryland School of Law, was graduated from The John Hopkins University (B.S., 1959) and the University of Maryland School of Law (J.D., 1970). Since her graduation from law school, she has been active in serving as a supervisor of the mental health—clinical education program recently instituted at Spring Grove State Hospital. She is, in addition, a research associate with the Baltimore law firm of Frank, Bernstein, Conaway and Goldman.

I. Introduction

For several years now thousands of long-suffering parents have been subjected to repeated renditions of a popular song from a highly-successful children's movie[1] in which the singer gaily assures them that a chimney-sweep's life is "as happy as can be." These assurances, unfortunately, stand history on its head. In point of fact, during the eighteenth and nineteenth centuries,

> A most forlorn waif of the cities . . . was the chimney sweep. . . . None of the work for children was more odious. Working night and day, their efforts usually hastened by some strong-hearted master burning straw behind them, they were subjected to all kinds of brutality. . . . Not only were they subject to cancer of the scrotum, the so-called chimney-sweep's cancer . . . but they also succumbed rapidly to the ravages of pulmonary consumption. Owing to the many serious accidents to which they were prone, the practice of sending boys up chimneys was finally abolished in England.[2]

As this example illustrates, sentimental disbelief and its opposite number, repugnance, have, like some two-headed Janus, stood at the gates of the realm of child abuses, averting and impeding exploration of its depths. We think of children as the natural objects of our love and protection. Most persons of ordinary sensibilities simply cannot bring themselves to believe that any adult, much less a parent, could deliberately inflict suffering on a helpless child.[3] Even those with some appreciation of history, mindful perhaps of the horrors of child labor, uncomfortably relegate child abuse to those shadowy practices of less-enlightened ages which, like bear-baiting, civilized man outgrew and discarded; or, at most, think of it as confined to that netherworld of poverty and pathology from which the average citizen is gratefully, if somewhat uneasily, insulated by social worker and law enforcement officer. But now and then a shocking incident splashes across the pages of newspapers and television screens, exploding all such pallisting misconceptions. Face to face with the spectre of child abuse, the ordinary person is frightened, disgusted, and filled with a desire to flee as from a nightmare. This near-universal repugnance from which even professionals are not immune[4] is too readily translated into ostrich-like avoidance or else a furious wish to have the authorities punish the guilty offenders severely.[5] Such reactions, of course, merely serve to foster evasion or suppression of the issue; they are scarcely conducive to effective action. That is why, in large measure, child abuse could exist in our midst for so long without any organized effort to combat it.

But while the public—and most professionals—disbelieved or averted their gaze, intermittent medical and social work research was compiling an appalling picture of the dimensions of the problem, developing incipient skills for its identification and management, and producing mounting pressure for remedial legislation. These scattered but persuasive efforts suddenly sparked nation-wide attention about eight years ago. A veritable deluge of activity ensued. Between 1962 and the present, a number of national conferences were convened, several books on the subject were published, a spate of articles appeared in the law reviews and the journals of medicine, psychiatry and social work, and every state in the Union, the District of Columbia, Guam and the Virgin Islands passed a child abuse reporting statute.[6] Predictably, many questions were left unanswered and many problems unresolved. Child abuse was not miraculously eradicated. The melancholy truth is that knowledge in this area remains rudimentary, imprecise and highly speculative; the law is "still in its genesis,"[7] and an efficient interdisciplinary approach to treatment yet to be devised.[8] Yet more than one observer has expressed concern that all this activity may have a cathartic effect on the still-eagerly-indignant public, easing its conscience by lulling it into believe that "everything that can be done has been done."[9]

It is the purpose of this article to review the developing body of knowledge and theory of child abuse, analyze the measures thus far adopted to eliminate or control it, and, wherever possible, suggest avenues of improvement.

II. Historical Perspective

This much, at least, is certain: the maltreatment of children is not the invention of modern society. Children have been beaten, maimed, and put to death by their elders since the dawn of recorded history. Although the circumstances and details have varied widely with time and place, at least four broad causes can be discerned: 1) the conviction that severe physical punishment was essential for proper discipline and education; 2) religious and superstitious beliefs; 3) cultural eccentricities; and 4) economic considerations.[10]

From the schools of ancient Sumer over 5000 years ago to the little red schoolhouse of American lore, the whip, the switch, the ruler and the hairbrush have been employed with varying degrees of severity to force children to "behave" and to cause them to be "receptive" to learning.[11] The biblical concept of sparing the rod and spoiling the child is too dismally familiar to most of us to require elaboration.

Children were severely chastised or killed to placate certain gods or to expel evil demons. "There was a time in most Christian countries when children were whipped on Innocents Day to make them remember the massacre of the innocents by Herod."[12] A sound thrashing to exorcise the offending devil was the prescribed form of treatment for epilepsy or other mental aberration. "There was a sacred chain in India expressly for this purpose."[13] Ritual sacrifice of infants was thought to insure bountiful harvests, fertility in women, good health, youth and vigor. "Not only were infants slain for medical uses, but there are reports of feeding the flesh to mothers to produce strong offspring and to favored siblings to make them stronger and healthier."[14] Infanticide was widely adopted as the ultimate solution to the problems of birth control, illegitimacy, congenital defects and pessimistic astrological prognostications.[15] "To insure durability in certain ancient structures some living creature was sometimes buried under the foundations of important buildings."[16]

Children have been subjected—often lovingly—to practices which are medically "classified as mutilating procedures."[17] Sometimes, as in the case of circumcision, the practice was deemed to be dictated by considerations of health or religion. But most often it was performed for purely cosmetic reasons; to achieve some exotic standard of beauty. This is most clearly exemplified by the foot-binding of the Chinese, and the cranial, neck and lip deformations of the Africans.

"Forms of mutilation which were clearly vicious were done by speculators who trafficked in children to set them up as professional beggars . . . (L)isted among the deformities inflicted upon children (were) gouged eyes, amputated or twisted arms and legs and broken or deformed feet."[18] To fill the family purse, fathers often sold their daughters into prostitution or their sons into slavery.[19] With the advent of the industrial revolution, children were obliged to undergo the novel tortures of the factory system with which every schoolboy is familiar and which need not be catalogued here.

Finally, to these four broad categories of cause and justification must be added the numerous injuries and deaths which have always occurred miscellaneously as a result of the heat of anger, the indulgence of sadism or the outright abandonment of infants.[20]

This, by no means comprehensive, litany of brutality is relevant to the subject of contemporary abuse in a number of ways. First, as has already been pointed out, it is often initially necessary to adduce a mass of shocking facts in order to brush away the webs of sentimental disbelief which preclude consideration of abuse as one of the possible sources of injury to children. Second, to the extent that there are aspects of human behavior which remain relatively constant through the ages, data collected on past manifestations of maltreatment may provide important insights for present-day researchers. Third, evidence of the pervasiveness, variety and continuity of this phenomenon must inform current efforts to deal with it; primarily, by dictating in advance the establishment of reasonable goals and reasonable expectations of success. Overly ambitious ends give rise to the use of intemperate means. Total elimination of child abuse, like total elimination of evil, is very probably an impossibility. The best that can realistically be hoped for is a more or less substantial degree of amelioration. This means that the weapons to be employed in the course of dealing with abusing parents must be carefully selected from the arsenal of *limited* war, less overzealousness result in the destruction of rights for offending and non-offending parents alike.[21]

III. Abuse Defined

Clearly, the term "maltreatment" is a generic term embracing widely variant forms of behavior. Specific acts or patterns of maltreatment may differ vastly as to quality and degree. The disparity between circumcision and the amputation of limbs for beggars' profits is almost too great to reconcile; yet both practices are housed under the same canopy. For purposes of legislation or remedial social action it is necessary to carve out a more precise definition of the kinds of maltreatment that will be designated and acted upon as abuse. To this end, child abuse must be distinguished from the "ordinary" or "normal" exercise of parental discipline; from manifestations of parental neglect; and even from the random or isolated episode of parental cruelty.

A. *For Purposes of Legislation:* Although there is a considerable variety in the statutory language employed to define the jurisdictional element of injury, all statutes exclude those injuries which may be properly attributed to accident. Twenty-two states, the District of Columbia and the Virgin Islands do so explicitly by speaking of the physical injuries inflicted by "other than accidental means;"[22] the remaining states do so by clear implication from discussion of cause in terms of "brutality," "abuse," and "maltreatment."[23] Beyond this, there is a division of opinion as to whether the reportable injury must have been *intentionally* inflicted. A block of states, including Maryland, leave little doubt that intent is an essential component of the offense by requiring that the injury be inflicted "intentionally," "willfully" or "maliciously,"[24] or by housing their statute in the penal code. Other states have taken a more expansive view. In these states it is not necessary for the injury to have resulted "from a deliberate act of commission, or omission. All that is required is an injury to the child resulting from some act, or from an omission, without regard to intent."[25] These statutes tend to blur the dividing line between abuse and neglect; indeed, excepting only accidental injuries, they list "neglect" or "willful neglect" as a cause of injury on a par with abuse.[26] While such provisions clearly carry the risk of inadvertently bringing some accidental situations within the purview of the statute, they have the distinct merit of expressly covering the grosser forms of neglect such as "homicide by starvation"[27] which many regard as rightfully a species of abuse, and which, under a statute such as Maryland's would have to be brought in under the more ambiguous clause "or otherwise mistreats such minor child to such degree as to require medical treatment. . . ."[28] The State of Washington, apparently uniquely, has designated sexual abuse as a cause of reportable injury.[29]

B. *For Purposes of Remedial Social Action:* In the eyes of the law, then, abuse consists of a clinical condition in a child[30] which is (a) presumably severe enough to warrant medical attention; (b) non-accidental in origin; and (c) occasioned with or without intent, depending upon the wording of the statute in the particular jurisdiction. This cool, dry legal jargon imparts little appreciation of the stark, flesh-and-blood reality to which it refers. Abuse, experientially, is what "non-accidental injury" means to the child victim and to his tormentor; what the physician uncovers and is expected to heal; what the social worker and law enforcement officer must treat or punish or both. For this view of abuse, there is no more appropriate vehicle than the following oft-quoted passage from a study by the Children's Bureau of the American Humane Association:

> The forms or types of abuse inflicted upon children is a negative testimony to the ingenuity and inventiveness of man. By far the greater number of injuries resulted from beatings with various kinds of implements and instruments. The hairbrush was a common implement used to beat children. However, the same purpose was accomplished with deadlier impact by the use of bare fists, straps, electric cords, T.V. aerials, ropes, rubber hoses, fan belts, sticks, wooden spoons, pool cues, bottles, broom handles, baseball bats, chair legs, and, in one case, a sculling oar. Less imaginative, but equally effective, was plain kicking with street shoes or with heavy work shoes.
>
> Children had their extremities—hands, arms and feet—burned in open flames as from gas burners or cigarette lighters. Others bore burn wounds inflicted on their bodies with lighted cigarettes, electric irons or hot pokers. Still others were scalded by hot liquids thrown over them or from being dipped into containers of hot liquids.
>
> To complete the list—children were stabbed, bitten, shot, subjected to electric shock, were thrown violently to the floor or against a well, were stamped on and one child had pepper forced down his throat.[31]

And, surely in a class by herself, was the "mother who rubbed red pepper into the genitals of her five year old daughter and then beat her when she screamed in agony. . . ."[32]

Certainly, no one would deny that the more bizarre or brutish forms of aggression should be classified as abuse. A more delicate task is involved in attempting to distinguish between abuse and neglect. As indicated above, some of the statutes have altogether given up on the attempt, at least insofar as the more egregious forms of neglect are concerned. And indeed, this approach has much to recommend it. Neglect is, quintessentially, the failure to act: a parent who in no way strikes his child but allows it to starve slowly, or to languish in its own excrement until it is crawling with maggots and covered with infection[33] has, perhaps, so far obliterated the distinction between mere omission and commission as to be deemed guilty of affirmative abuse. Yet there are equally compelling reasons for continuing to differentiate between the two. First, there are more moderate manifestations of neglect which less clearly straddle the boundary of abuse or fall well short of it, and, which, arguably, demand different treatment. In those jurisdictions where the abuse statute is located in the penal code, a prosecution for abuse will be a criminal proceeding, and conviction will bring the imposition of criminal penalties, whereas a finding of neglect will be dealt with under the aegis of the juvenile court authority. Second, where the legislative scheme contemplates primarily remedial rather than punitive action, there is possibly an even more cogent reason for making a proper differential diagnosis; research to date suggests that the psychopathologies of neglect and abuse are significantly different, with the neglecting parent being a somewhat likelier candidate for successful rehabilitative casework than his abusive counterpart.[34]

But, while comparisons between neglect and abuse are undeniably useful and practical, the natural thrust of research, and ultimately the most illuminating, is to explore the differences between what is "normal" on the one hand and "abnormal" on the other. To erect a standard of parental behavior and then designate all departures from it, of whatever shade or degree, as aberrations, is no mean task, especially in a society such as ours which prizes individualism and diversity so highly. To say that in each case the actions of parents must be judged with reference to the welfare of the child, is to beg the question. Yet our juvenile court judges are, perforce, unabashedly making such determinations every day. And if the law of torts can live with that ephemeral creature, the reasonably prudent man, then the law of child protection can live with the concept of the reasonably-well-cared-for child. This is, after all, one area in which the requirements of the law,[35] the constucts of the social scientists and the instincts of laymen can coincide without too much strain. At a *bare minimum*, the "normal" parent is conceived of as one who makes a *bona fide effort* to provide his child with the basic necessities of life—food, clothing, shelter, medical care[36]—to the extent that his resources (or those of the State available to him) will permit, and, crucially, attempts to structure the child's life in the light of what he considers to be *the child's own best interests*. He may frequently falter; he may sometimes misconstrue the direction in which those interests actually lie; he may be stupid or lax or poor or inept; which is to say, he may be a better or a worse parent. But, conversely, so long as he does not ignore life's essentials or affirmatively try to harm his child, he remains well within the range of "normal" parenthood.

Yet, the inescapable truth is, that in our society the "normal" parent not only resorts to the use of physical force against his child, but will often be heard to advocate its use as a positive good. The "old-fashioned" spanking, a gentle euphemism by which this resort is rendered respectable, is thought to possess both educational and therapeutic qualities, i.e., the parent strikes his child to "teach" him not to do something, or to vent his own anger or frustration at something the child has done or left undone.[37] Clearly, then, the threshold question which must be answered is whether this characteristic resort to force becomes something *qualitatively* different when wielded by the abusing parent, or whether abuse is, after all, only a matter of degree.

The traditional view (if that term can be aptly used to describe anything so new and faltering) is that the abusing parent does indeed use physical force in a qualitatively different way. The full flavor and import of this view is psychosis. The abusing parent is seen as pursuing punishment as an end in itself, unrelated to anything the child has done or left undone:

> This is the outline of abuse. It is not the impetuous blow of the harassed parent nor even the transient brutality of an indifferent parent expressing with violence the immediate frustrations of his life. It is not the too severe discipline nor the physical roughness of ignorance. It is the perverse fascination with punishment as an entity in itself, divorced from discipline and even from the fury of revenge. It is the cold calculation of destruction which in itself requires neither provocation nor rationale. . . . The one invariable trademark of the abusing parent regardless of economic or social status is this immersion in the action of punishing without regard for its cause or purpose . . . not punishment to fit the crime but punishment without crime. . . . Like an earthquake it (strikes) without warning, and this (is) part of its terror.[38]

An offshoot or variant of this view is that "cause" for punishment does exist somewhere in the nightmarish recesses of the parent's mind; that pain is inflicted on the child because he has —predictably—failed to conform to his parent's bizarre, unrealistic expectations.[39]

But as epidemiological studies of the subject progress, a new view appears to be emerging.[40] It holds that it is quite improper to speak of abuse as a single phenomenon "in the sensational manner of ten years ago. We ought to be talking about child abuses, in the plural, as we now talk about juvenile delinquencies." The kind of abuse which arises from "psychological situations, i.e., the personality status of the persons involved" is viewed as representing only a relatively minor proportion of the total; and it is thought to be a grave mistake "to generalize from these psychologically-motivated cases to the entire phenomenon." The thesis is essentially that "abuse is predominantly a cultural phenomenon and not the result of psychotic personalities." That is, abuse is considered to be merely reflective of the violence which permeates all levels and phases of American society,[41] although it is admitted that there is as yet "no established direct connection between the use of force on children and other forms of violence." More particularly, abuse of children is viewed as a terrible by-product of the ready and culturally-sanctioned use of force for purposes of discipline. We are seen as pre-eminently competitive people who employ force more or less intuitively in order to train our children "to meet the combative expectations of the society" for which they would be less successfully prepared were they raised "in complete warmth and with a total sense of security." Abuse is thus, for the most part, not a qualitatively different species of behavior at all, but a matter of degree: a matter of regular discipline that has somehow gotten out of hand.

It is probably still premature to hazard a final judgment, but it is possible that what appears to be an irreconcilable theoretical dispute may yet be resolved by the simple expedient of sorting out and standardizing terminology,[42] and then awaiting the statistical results of further studies. Upon a little reflection, it becomes apparent that the areas of agreement between the two schools of thought may be significantly broader than their areas of disagreement. Though the qualitative-difference thesis of the "psychosis school" suggests a monolithic approach, even its most ardent proponents recognize that there are various degrees of abuse, from the more moderate to the grossly severe.[43] They tend to gloss over the former and to concentrate on the latter; but there is in this at least implicit recognition that abuse may well be a plural phenomenon. The "cultural school," on the other hand, readily admits that the more brutal or bizarre manifestations are probably psychotically induced, yet they contend that these cases are proportionately overshadowed by the instances of discipline-gone-awry. Analysis thus suggests that both schools are simultaneously talking about the same thing under different labels—(a) "Psychotic Abuse" and (b) "Moderate" or "Disciplinary" Abuse—with each side emphasizing the type that figured most prominently in its statistical sampling; and that broader-based future studies will succeed in bringing them closer together still.

IV. The Parent in Profile

The classic picture of "cultural abuse" is that of a parent who sets out to discipline a child "for his own good," and then loses control; a mother who means to spank her son for a poor report card and in the white heat of anger, ends up by breaking the boy's arm.[44] Perhaps the picture also extends to the father who, with a few drinks in him, habitually caps his indulgence by beating his children "to teach them respect" for his dubious authority. These parents "intend" at the time "to inflict pain, but they do not intend the outcome."[45] The extent of the damage appears to shock them and to cause feelings of fear and remorse. This is inferred from the fact that in a large proportion of cases—about 60% in a recent study[46]—the request for help and/or the report to the authorities came from the abusing parent himself or another member of the household.

But there are two aspects of many abuse situations which have not as yet been satisfactorily explained by the cultural theorists. First, studies so far reveal uniformly that abuse is predictably repetitive; the parent who abuses once is likely to do so again and again.[47] It is really something of an exercise in circular reasoning to say that these are people who, though they are sorry for what they have done, have been so imbued with society's thirst for violence that they invariably succumb to it again at the slighest provocation. Second, and even harder to justify in cultural terms, is the strange predilection of many abusing parents for selecting as victim only one of

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a number of children in the family."[48] Such selectivity is somehow inconsistent with the picture of the "good" intentions gone sour. It may just be that these are the cases in which the boundary of pathology has been crossed; but if this is so, it has not been clearly expressed in these terms in the published research to date.

The classic picture of aberrational abuse is that of the father who methodically wraps newspapers around his son's arm and then sets them ablaze.[49] The question is, what causes such destructive behavior? Some psychiatrists have apparently entertained the theory that certain people are congenitally pre-disposed to excessive violence and that only differences in environment will determine whether such tendencies will be encouraged or suppressed.[50] The more conventional explanation is that forces in the parent's own life-history produced a severe "defect of character"[51] typical of the sociopath, or else produced outright psychosis. This view is heavily indebted to a number of studies which compiled data on the basis of interviews with the abusing parents themselves (or knowledgeable relatives) along with supportive data garnered from the observations of trained workers. From these studies there emerged the tragic realization that most, if not all, abusing parents have themselves been the victims of neglect or abuse during childhood, and that as adults, they are "following a distortion of the golden rule, 'Do unto others as you have been done unto' . . . often despite very conscious resolves to do differently."[52]

In capsule form, the developmental pattern of the abusing parent's own life is a constant dreary cycle of rejection, aggression, frustration, hostility, guilt and so on, down through the catalogue of the most negative emotional experiences. Beginning in infancy, he is the hapless subject of a breakdown in mothering; of those "subtle ingredients of tenderness, of awareness and consideration of the needs and desires of the infant and of appropriate emotional interaction with it . . . qualities (subsumed) under the title of motherliness."[53] This may or may not be accompanied by deficits in the practical or mechanical aspects of mothering such as feeding, holding, clothing or cleaning.[54] It does not imply a lack of parental attention. On the contrary, there is a great deal of attention but it is in a pattern of

> . . . intense, pervasive, continuous demand . . . excessive, not only in degree, but, possibly more importantly in . . . prematurity. Performance (is) expected before the child (is) able to fully comprehend what (is) expected or how to accomplish it. Accompanying the parental demand (is) a sense of constant parental criticism. Performance (is) pictured as erroneous, inadequate, inept and ineffectual . . . not enough . . . not right . . . at the wrong time . . . (bothersome to) the parents, (tending to) disgrace the parents in the eyes of the word, or (failing) to enhance the parents' image in society.[55]

This pattern of demand and criticism produces low self-esteem, a profound lack of self-confidence and an intense, unsatisfied yearning for affection or approval, accompanied by a persistent disbelief in the possibility of ever finding it. Transferring towards the rest of society attitudes originally felt towards parents, and expecting only further rejection, the abusing parent withdraws "to lead a life which is described as alienated, asocial or isolated."[57] When he marries, "like many other neurotic people (he) demonstrates an uncanny ability to become involved with . . . (a person) who tends to accentuate rather than solve (his) problems . . . needy, dependent, unable to express clearly (her) needs, and at the same time demanding, critical and unheeding. . . . The marriage (becomes) one more situation reinforcing (his) sense of disappointment and hopelessness."[58]

But when his own child is born, the abusing parent has "one hope left. When all of the rest of the world has failed him, (he) will look to the child in a last desperate attempt to get comfort and care."[59] The sought-for role reversal is, of course, doomed to failure. The child's own needs are too imperious; it is he who, in his helplessness, requires the comfort, the care and the protection of his parent. When the child cries, or soils himself[60] or fails to obey instantaneously, or in any other way intrudes his own needs into the situation, he destroys this cherished illusion of panacea. The parent either interprets the crying or the soiling as implicit criticism of his own capabilities as parent, or sees the child as the embodiment of all the "bad" things he himself did as a child which earned him the disapproval of his own parents. And this his own past has rendered intolerable. He, therefore, lashes out. The baby, of course, is haplessly destined to repeat his "transgressions," supplying ever-mounting proof of his "obstinancy," "wickedness" and "lack of concern."[61] He thus makes himself the target of the pent-up impotent fury, frustration and hostility the parent has never dared express against his own parents. Unwittingly, the same futile pattern of development is recreated for the child. And so the tragic cycle of abuse perpetuates itself.[62]

This is postulated as the basic abuse-producing mechanism. There is by no means universal agreement as to its validity.[63] But if it is correct, then it serves to explain the puzzling lack of remorse or shame, indeed the militant self-righteousness displayed by many abusing parents when called to account for their actions.[64] It also helps to explain the notoriously high percentage of recidivism. But the proponents of the hypothesis are the first to decry the tendency to oversimplify. They point out that essentially the same background can give rise to a host of clinical considerations ranging from relatively mild neurosis to the most exaggerated forms of psychosis,[65] making it probable that, eventually, more than one cause for abuse will be identified. They point out that there are other, secondary psychological factors which "are potent accessories in instigating abuse and in determining which infant is selected for attack; three such factors (being) unresolved sibling rivalry, an obsessive-compulsive character structure and unresolved Oedipal conflicts with excessive guilt."[66] And finally, they point out the role that other, more "objective" factors may play in the instigation of abuse: the sex of the child (a boy when a girl was wanted); the innate characteristics of the child (whether placid or aggressive); the health status of the child (whether born with congenital defects requiring a greater degree of attention); and the time of the birth (whether the result of a premaritally conceived pregnancy or an accident too soon after the birth of a previous child).[67]

Seen in this light, the abusing parent is no longer quite the monster of first impression, but a tragically unbalanced individual whose need for treatment must take second place only to his child's need for protection. Given the present state of knowledge, there does not appear to be any viable alternative to accepting this hypothesis, at least with regard to the psychologically-motivated forms of abuse, if not with regard to the culturally-induced forms. To reject the thesis, is to be left with the monster unexplained, untreatable, unsalvageable and fit only for the tender ministrations of the criminal law, if and when he is apprehended.

V. The Incidence of Abuse

There are no really reliable figures on the incidence of child abuse and there is every indication that such figures will never be fully developed. Abuse is a low-visibility phenomenon. It almost invariably occurs within the privacy of the home. The passive parent is usually reluctant to inform, and if there are other children, they, like the victim himself, are either too young or too terrified to talk. Friends, neighbors, relatives are likely to be subject to that reluctance to get involved, which in our time has taken on "a special malevolence."[68] There is thus general agreement that for every case which is brought to the attention of the authorities, one or more cases go unnoticed, misdiagnosed and unrecorded. The American Humane Association has estimated that the number of child abuse cases in the United States annually is 10,000, with a majority of these cases being unreported.[69] An editorial in the Journal of the American Medical Association made the dire prediction that abuse "will be found to be a more frequent cause of death than such well-recognized and thoroughly studied diseases as leukemia, cystic fibrosis and muscular distrophy, and it may well rank with auto accidents and the toxic and infectious encephalitides as causes of acquired disturbances of the central nervous system."[70] In 1962, Dr. C. Henry Kempe and his associates at the University of Colorado School of Medicine undertook a nationwide survey of hospitals to determine the incidence of abuse in a one-year period. "Among 71 hospitals replying, 302 such cases were reported to have occurred; 33 of the children died; and 85 suffered permanent brain injury."[71] The American Humane Association released in 1963 its findings based on a nationwide survey of press reports of abuse during the previous year: 662 cases were uncovered, 178 of which were fatal.[72] One study revealed that 71 cases of abuse were reported in Iowa in a 6 month period[73] and another survey showed that Cook County Hospital admits abused children at the rate of approximately ten a day.[74] In Maryland, in the second six month period following enactment of the child abuse reporting statute, 187 incidents of suspected child abuse involving 224 children were brought to the attention of the authorities. Of these, Baltimore City reported 65% and the Counties 35%.[75] During 1965 Brandeis University conducted a study "designated to provide an indirect estimate of the actual incidence of child abuse."[76] The survey provided "an estimate of the upper limit in the total United States population of the incidence of child abuse known beyond the confines of the abused child's home. The upper limit for the year ending October, 1965, was between 2.53 to 4.07 million for a population of about 190 million, or about 13.3 to 21.4 incidents per 1000 persons. The actual incidence rate, however, was not unravelled by the survey and is likely to be considerably lower."[77]

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It should perhaps be noted that passage of the abuse reporting statutes combined with increasing awareness of the problem on the part of professionals and the general public alike may cause a temporary upswing in the number of reported cases which should not be taken as necessarily indicating an increase in the actual occurrence of abuse.

Certain demographic features of abuse are of interest and deserve brief mention. The abused child is likely to be very young, generally under three years of age.[78] There is some indication that the critical period is the first three months of life and that if the parent has tendencies toward abusive behavior, these will manifest themselves very early.[79] A slightly higher percentage of boy babies are abused than girl babies.[80] This may be related to the more aggressive characteristics of the male which intrude more frequently or more disruptively on the parent's consciousness, but this is mere speculation. Proportionately more non-white than white children are involved in reported incidents[81] but this may be attributable to the poor financial situation of the family which is more likely to bring it into contact with public agencies or emergency facilities of hospitals where visibility is enhanced, and reporting more likely to occur. Finally, somewhat more men than women are involved in abusing children, but more women than men are apparently the perpetrators in the fatal accident situations. "This may be related to the younger age of the fatally injured children as compared to the age of all abused children and to the fact that women have a larger part than men in the care of younger children."[82]

VI. The Identification of Abuse

In 1946 Dr. John Caffey alerted the medical profession to the problem of child abuse by noting the frequency with which multiple fractures of the long bones of unknown origin were associated with subdural hematomas of traumatic origin.[83] Dr. Caffey concentrated on the condition of the child and did not speculate on the possible source of the trauma. In the early fifties, articles by Drs. Lis, Frauenberger and Smith, focusing again on this coincidence of fracture and hematoma, suggested tentatively that parental carelessness might be somehow involved.[84] Drs. Woolley and Evans, in 1955, made an enormously important contribution by demonstrating that the radiologic manifestations of abuse and of accidental injury are significantly different, and by emphasizing undesirable environmental factors, including uncontrollable aggressions of parents as a cause of the child's injuries.[85] Returning to the subject in 1957, Dr. Caffey further highlighted the misconduct of parents by drawing attention to the frequency with which the history or explanation elicited from the parents was incompatible with what was known about the injury.[86] Social workers such as Elmer and Boardman began to make their contributions to the unravelling mystery.[87] In 1961, the American Academy of Pediatrics scheduled a symposium on the problem at its annual meeting. The following year, Dr. Kempe and his associates published the results of their landmark study in the Journal of the American Medical Association in which, among other things, they christened the problem "the Battered Child Syndrome."[88] Finally, the Children's Bureau of the United States Department of Health, Education and Welfare and the Children's Division of the American Humane Association held meetings of experts and conducted surveys which gathered invaluable information and resulted in the drafting of model legislation for the guidance of the States.[89]

For the physician on whom the task of identification is most likely to devolve at least initially, study and experience have evolved a kind of blueprint of suspicion or checklist of the indices of possible abuse.[90] First, is the age of the child characteristically under three years? Second, is the general health of the child indicative of overall neglect? Third, is there an inordinate amount of bruising and other soft tissue injury which is not attributable to any peculiar skin or blood condition? Fourth, is there the characteristic distribution of fractures which, radiologically, give the appearance of being non-accidental in origin? Fifth, is there subdural hematoma, especially in the child who is too young to crawl or walk? Sixth, is there evidence of other injuries in varying stages of healing suggestive of prior instances of abuse? Seventh, is the history elicited from the parents too improbable or incompatible with the nature of the injuries?[91] And eighth, do any new lesions occur during the child's hospitalization or does he thrive under proper care and supervision?

It need hardly be said that the early identification of abuse is the *sine qua non* of treatment and future protection. The doctor who because of incredulity fails to consider or rules out parental abuse as a source of injury may unwittingly, and despite the noblest of intentions, contribute to the further injury or even the death of that child.

VII. The Legislation

State legislatures had four model statutes upon which they could draw. These were proposed by the United States Children's Bureau, the Council of State Governments, the American Humane Association, and the American Medical Association. The model draft which proved to be the most influential was that of the Children's Bureau.[92]

The statutes have been so ably and comprehensively analyzed in a number of publications,[93] that to do so here would be needless duplication. The basic statutory scheme is as follows: there may or may not be, at the outset, a statement of legislative purpose to guide implementation into primarily punitive or therapeutic channels; this is followed by an exposition of the jurisdictional elements of (a) the age of the children subject to reporting and (b) the nature of the reportable injury whether intentionally inflicted or not);[94] the statute then sets up the machinery by which the reporting is to be implemented—it designates the target groups mandated to report (whether limited to members of the medical profession or extending through other professions to "any person" having knowledge of abuse);[95] outlines the nature of the duty to report (whether mandatory or permissive, whether failure to report is subject to penalty or not);[96] defines the form, content and manner which the actual reporting is to take (whether written or oral, within what length of time after discovery); identifies the target resources for receiving reports (whether social welfare agency or law enforcement agency); indicates the action mandated or sought from the receiving agency (investigation, decision to prosecute or to treat, decision to seek removal of the child from the abusing home); sets up a central registry for filing and maintaining accumulated data on abuse;[97] and finally, grants immunity from legal action to those reporting under the act.

It is proposed here to comment only upon the two most salient features of the legislation: the selection of social welfare or law enforcement agency as the report-receiving resource in the community, and the grant of immunity from suit.

Siegel 1970

A. *The Receiving Source*

"This is the most sensitive area of the whole discussion of reporting legislation. Yet analysis shows this to be the most confused, and confusing aspect of the comparative study."[98] Roughly half the states incorporated into their statutes a general purpose clause indicating a legislative intent to invoke the entire spectrum of protective social services in order to enhance the health and welfare of the child and prevent further abuse.[99] But even in those states without a purpose clause, the designation of an agency to receive and act upon reports is of critical importance in determining the effectiveness of the legislation. "The right choice will bring into play the appropriate resources. A poor or bad choice may produce results not contemplated in the law."[100] To state the proposition simply, if the legislature was primarily concerned with crimes and punishments, then the logical selection as recipient of the report would be the local police, sheriff or prosecuting attorney; but if the objective was therapeutic, then a more appropriate choice would be the local child welfare agency or, secondarily, the juvenile court.[101] In fourteen states, the issue was straddled by designating more than one agency as eligible to receive reports of child abuse. Whether this flexibility was the result of indecision in the legislature, a compromise of conflicting views or a desire to provide alternative courses of action to cover unforeseeable contingencies, is not clear.[102]

The lines of argument in favor of selecting either a law enforcement agency or a social welfare agency are, despite their crucial importance, relatively simple. Those who favor reporting to the police or prosecutor[103] point out that in many communities, law enforcement agencies are the only resources available to cope with emergencies on a twenty-four hour basis; that the agency designated to receive the report is also mandated to investigate the circumstances and possibly prepare the case for presentation in court, a function for which the police are eminently suited by training; that after all, assaults on children are crimes and, therefore, necessarily within the province of law enforcement; and that finally, the quick intervention of the police followed by conviction of the abusing parent can prevent a repetition of assaults of the child, if only by virtue of removing the perpetrator from the home.

Proponents of the social welfare approach[104] counter by arguing that the intrusion of the police on the threshold of investigation necessarily imparts a punitive flavor to the entire proceeding which may cause undue embarrassment for families ultimately found to be innocent, or generate such hostility and fear in the abusing family that they will refuse to cooperate in any plans for the benefit of the child; that punishment of the parent should be sought only when all other attempts to ameliorate the situation and keep the family intact have failed; that punishment does not get at the root causes of abuse and so does not preclude repetitions in the future; that quick removal of the abused child by the police may indeed secure his safety but does nothing to protect the remaining children of the family who may then be exposed to assault; that if insufficient admissible evidence to obtain a conviction is gathered, the police and prosecutor are likely to lose interest in the case, leaving the child in an extremely precarious situation; and that finally, in pursuing what ought to be the overriding objective of protection for the child, judgments must be made at every stage which require the special training and insights of social workers; for example, whether the juvenile court authority should be invoked for the immediate removal of the child or whether it is safe to leave the child in the same, under supervision, while traditional casework or psychiatric treatment is tried on the parents.

There is thus general agreement that for every case which is brought to the attention of the authorities, one or more cases go unnoticed, misdiagnosed and unrecorded.

There is obviously much merit on both sides of the controversy. Each institution should, arguably, perform only the role for which it is best equipped and not infringe upon the other's prerogatives. But as a practical matter this is impossible in an area such as child abuse where responsibilities overlap and become almost indistinguishable. An interdisciplinary approach is almost mandated by the necessities of the situation, and what is called for is ever greater cooperation between the personnel of both groups. One solution, adopted in Maryland, is to channel the initial report to the social welfare agency for preliminary investigation and then require a summary of findings to be forwarded to the State's Attorney's Office for his decision as to the wisdom of pursuing or foregoing prosecution. This approach, however, requires the establishment of easy avenues of communication between the two offices and the development of mutual confidence and respect, which can be readily frustrated by the notoriously high rate of personnel turnover in social service agencies. Another solution, and one which is likely to be easier to implement in the big cities than in the rural counties is to establish within the designated agency a specialized unit with "postgraduate" training—an elite corps of social workers within the welfare agency, tutored in the arts of investigation and case preparation; or a special Youth Division within the police department outfitted with the social worker's manual.

B. *The Immunity Provisions*

To encourage reporting, and to free the reporting source from fear of retaliation by the infuriated parents, every one of the statutes included a provision granting some form of immunity. Typical language is, "Any person participating in good faith in the making of a report pursuant to this act or participating in a judicial proceeding resulting therefrom shall in so doing be immune from any liability, civil or criminal, that might otherwise be incurred or imposed."[105] The local statute must be referred to, however, since curiously, some states provide for immunity only against civil actions (Maryland being one, Idaho the other) while thirty-eight states provide that immunity shall apply only when the report is made in "good faith" or "without malice" (an obvious attempt to exclude from immunity the reporter whose only purpose is to harass or injure the person about whom the report is made).[106]

A sub-category of the immunity question is the matter of statutory waiver of privileged communications between doctor and patient and, in some states, between husband and wife. The pattern is irregular;[107] some states waive the former privilege but not the latter; others do the reverse. Maryland is amongst a group of states which has no waiver of either privilege.

Though social workers, attorneys and members of other professions may have either legal or ethical problems regarding breach of privileged communications,[108] the waiver provisions were designed primarily to ease the concern of the medical profession about the propriety of divulging confidential information and the possibility of legal action arising therefrom.

The American physician has been accused of catering to "Lexphobia,"[109] the failure to act for fear of incurring some form of legal liability. This phenomenon is usually discussed in the context of the need for good samaritan legislation, but it is peculiarly appropriate for consideration within the context of the child abuse problem (where there is necessarily such heavy reliance on the physician's skill) because "a doctor who is burned at the jurisdictional stake once is not likely to play with diagnostic matches."[110] There is supreme irony in all of this because such fears are largely irrational, with little or no basis in the law:

> . . . Such potential liability might be in the nature of civil or criminal responsibility for defamation, civil liability for invasion of privacy by disclosing of "private facts" or by placing parents in a false light, or the possible civil liability for breach of confidence. Yet every reported American case in which a physician has made disclosures concerning patients for the protection of third parties has resuted in recognition of a privilege on the part of the physician and a denial of liability.[111]

Protection in the law for the reporting physician is of a two-edged variety. In a tort action against him, the doctor could raise the defense of absolute or qualified privilege to make good faith reports to the authorities concerning suspected criminal or tortious conduct.[112] In a suit for breach of the statutory[113] physician-patient privilege for confidential communications, the doctor would have the benefit of ample precedent[114] to the effect that the privilege was designed to protect the patient; that the patient is the child and not the parent; and that it would be a perversion of the privilege to permit the attacking parent to claim the privilege on behalf of the child in order to protect his own, divergent interests. From a purely legal standpoint, then, the provisions on both waiver and immunity are, with respect to the physician, mere surplusage. But as they apparently fulfill a very practical, psychological role, it is prudent policy to retain them.

VIII. The Courts

Because of either difficulty in obtaining sufficient evidence to warrant a criminal prosecution, or legislative intent to pursue a social welfare approach, the abuse situation, if it brushes up against an agency of the law at all, is likely to be submitted to the jurisdiction of the juvenile court. Two aspects of the court's handling of the problem merit comment.

By tradition and intellectual persuasion, the juvenile court judge is likely to attach high priority to preserving the integrity of the family unit wherever possible.[115] Removal of the children is often subliminally viewed as a species of punishment for wayward parents.[116] Thus, many times, a cunning apology by the abusing parents is sufficient to outweigh the protestations of the caseworker, and induce the judge to return the child to his home.[117] This decision often has the direst consequences for the child. While no conscientious judge can be expected to ignore the rights of the parents, however abhorrent their actions, it is submitted that there is no justification for giving them undue weight or importance either. The safety and well-being of the child must take *actual* as well as theoretical precedence. In the light of the shocking rate of repeated abuse, doubts must be resolved in favor of immediate removal of the child from the injurious environment, regardless of whether other means for improving the family situation are adopted or not.

In addition to establishing and adhering to a hierarchy of priorities, the courts must somehow resolve the perplexing evidentiary problems which beset the attempt to deal with abuse in a legal framework. The dilemma is perhaps more intense when the litigation takes the form of a criminal prosecution, but with the Supreme Court's recent forays into the area of juvenile court procedure and due process, such distinctions are likely to fade in importance. The problem is elementary: evidence of abuse that will "hold up" in court is extremely difficult to obtain; there are either no witnesses to the abuse or else no witnesses who are willing to testify. Yet, a failure to "prove" abuse may result in returning the child to the tender mercies of his parents, by now even more incensed at all the trouble they have been put to, and seeking a convenient scapegoat. One court resolved the dilemma by importing into the criminal law the tort law doctrine of *res ipsa loquitur* and holding that the injuries of the child spoke for themselves.[118] This case has been much criticized and followed not at all. The main stumbling block has been reluctance to tamper with that most venerable of all protections for the criminal defendant, the allocation to the prosecution of the burden of proving guilt beyond a shadow of a doubt. Short of holding that what the legislature giveth, the legislature can take away, meaning a change in the statutory rules of evidence to permit the introduction of hearsay, the only practical solution appears to be the compromise adopted by the court in *Matter of Young*.[119] There the court

> employed a formula whereby the burden of proof relating to the allegations in the petition would remain upon the petitioner to establish by a preponderance of the evidence. However, once the existence of substantial injuries sustained by the child while in the custody of his parents has been proven the petitioner would be deemed to have established a prima facie case and the burden of offering a satisfactory explanation as to the cause of the injuries would shift to the respondent.[120]

In the light of the shocking rate of repeated abuse, doubts must be resolved in favor of immediate removal of the child from the injurious environment.

IX. Conclusions

If we were really devoted to the elimination of child abuse at all costs, we could accomplish this most efficiently by removing to institutions not only the victim himself but all his brothers and sisters, and then forcing the parents to submit to compulsory sterilization. The fact is, we are not devoted to this objective at any cost. In a democratic society which prides itself upon the legal protection afforded the most heinous criminal, solutions which are destructive of the rights of abusing parents, and therefore, ultimately, of all parents, cannot be tolerated.[121] A sensible regard must be maintained for the interplay of rights and obligations, however, and due weight given to the extreme helplessness of the child victim. Doubts must be resolved in his favor, and burdens of proof perhaps shifted to his advantage. Beyond this, there is little that the law can lawfully do. The abuse reporting statutes are essentially merely casefinding tools; stimulants to reporting. It is naive to think that a problem so vast and complex, with roots so deep in the history of man, can be eliminated by the mere enactment of a piece of legislation. It is equally naive to think that there will ever be available sufficient resources, either in terms of money or of trained manpower, to achieve successful rehabilitation of each situation of abuse that is unearthed. Indirect help may come from many sources: from expanded access to birth control information and liberalization of the abortion laws; from increasd success in dealing with the problems of alcoholism and easing the manifold frustrations of poverty; from increased public awareness and commitment to social welfare philosophy. But the woes of Wednesday's children, however much diminished, are not likely ever to be completely dissipated this side of Utopia.

Footnotes

[1] MARY POPPINS.

[2] R. E. HELFER & C. H. KEMPE, THE BATTERED CHILD 12 (1968). (Hereinafter, HELFER & KEMPE).

[3] *See* 6 Med. Sci. & L. 2, 3 (1966); 45 ORE. L. REV. 114, 117 (1966); 13 CATHOLIC LAW 231, 232 (1967); 12 VILL. L. REV. 313 (1967).

[4] Interview with James Anderson, District Supervisor of the Protective Services Division of the Baltimore City Department of Social Services, Oct. 15, 1968: Mr. Anderson stated that even his specially-trained workers often react with horror to what they discover during home visits, and that an important part of his job of supervision consists of "just letting them blow off steam in my office."

[5] *See e.g.*, 44 DENVER L. J. 3 (1967).

[6] Citations to all statutes may be found in HELFER & KEMPE, Appendix C, 237.

[7] 52 A.B.A.J. 734 (1966).

[8] *See* 124 AMER. J. PSYCHIAT. 10 (1968).

[9] 52 A.B.A.J. 734 (1966).

[10] HELFER & KEMPE 3.

[11] *Id.*

[12] *Id.*

[13] *Id.*

[14] *Id.* at 9.

[15] *Id.* at 6.

[16] *Id.* at 9.

[17] *Id.* at 5.

[18] *Id.*

[19] *Id.* at 6.

[20] *Id.* at 9.

[21] In this connection, it is prudent to remember the old bromide that hard cases make bad law.

[22] CHILDREN'S DIVISION OF THE AMERICAN HUMANE ASSN. PART I, CHILD ABUSE LEGISLATION: ANALYSIS OF REPORTING LAWS IN THE UNITED STATES 10 (1966). (Hereinafter, CHILDREN'S DIVISION, PART I).

[23] *Id.*

[24] *Id.* at 11.

[25] *Id.* at 13.

[26] *Id.* at 12.

[27] This is the title of an article appearing in 186 A.M.A.J. 458 (1963).

[28] MD. ANN. CODE, art. 27, §11A (Supp. 1967).

[29] WASH. REV. CODE ANN., §§26.44.010-060 (Supp. 1968).

[30] The label "Battered Child Syndrome" was first affixed to the phenomenon of abuse by Drs. C. H. Kempe, F. N. Silverman, B. F. Steele, W. Droegemuller and H. K. Silver, writing in 181 J.A.M.A. 17 (1962). In defining the term, the doctors said, "The Battered Child Syndrome is a term used by us to characterize a clinical condition in young children who have received serious physical abuse, generally from a parent or foster parent. The condition has also been described as "unrecognized trauma" by radiologists, orthopedists, pediatricians, and social service workers."

[31] V. DE FRANCIS, CHILD ABUSE—REVIEW OF A NATIONWIDE SURVEY 5-6 (1963) *(A Study of Child Abuse by the Children's Bureau of the American Humane Association)*.

[32] L. YOUNG, WEDNESDAY'S CHILDREN—A STUDY OF CHILD NEGLECT AND ABUSE 46 (Hereinafter, YOUNG). The title of the book comes from an anonymous rhyme, attributing to children various characteristics according to the day on which they were born. Wednesday's Child is said to be "full of woe."

[33] HELFER & KEMPE 83, 85; Jones v. United States, 308 F.2d 307 (1962) (deplorable condition of neglected children discovered in basement).

[34] *Compare* HELFER & KEMPE 113, "The abusing parent and the neglecting parent have many common characteristics. Both need and demand a great deal from their infants, and are distressed when met by inadequate response, so it is not surprising that we occasionally see an infant or child who is both neglected and abused. Yet there is a striking difference in these two forms of caretaker-infant interaction. The neglecting parent responds to distressing disappointment by giving up and abandoning efforts to even mechanically care for the child. The abusing parent seems to have more investment in the active life of the child and moves in to punish it for its failure and to make it 'shape up' and perform better" *with* YOUNG 127, "It is much easier to develop a daily routine of living with parents who respond as children than to stop physical abuse of children by parents who seem to measure all intervention by the extent of the power it represents. By and large, abusing parents were respectful to those they feared, manipulative with those they could use, and indifferent to everyone else."

[35] *See* 1 BLACKSTONE, COMMENTARIES 452 (comparison of Roman and common law philosophies on legitimate extent of parental authority); Jones v. United States, *supra* (legal duty to take action to preserve life of another, as opposed to merely moral duty, is based on statutory duty to care for, status relationship, contractual duty to care for, or voluntary assumption of care plus seclusion of helpless person from others who might render aid); Emery v. Emery, 45 Cal. 2d 421, 289 P.2d 218 (1955) (parental immunity from tort liability derived from recognition of parental right to discipline; but discipline must not exceed reasonable limits); Barry v. Sparks, 306 Mass. 80, 27 N.E. 2d 731 (1940) (excessive chastisement of children will cause the law to refuse to recognize parental privilege); Hersey v. Hersey, 271 Mass. 545, 171 N.E. 815 (1930) (parental rights to custody and control of children subject to powers of the state; abuse of rights may lead to forfeiture of custody). *See also* 18 U. FLA. L. REV. 503 (1965); 15 DE PAUL L. REV. 453 (1966). *But see* 29 OHIO S. L. J. 85 (1968) (Criticism of vague statutes governing child neglect trials and simultaneous delegation of power to the judiciary which allows courts to impose their individual notions of child care and morality on parents); *and* Nicholas v. State, 32 Ala. App. 574, 28 So.2d 422 (1946) (parent sole arbiter of degree of punishment; all punishment is *per se* reasonable which does not give rise to dis-

figurement or permanent injury or is not inflicted maliciously).

[36] *See* 41 Geo. L. J. 226 (1953) (Note, *Compulsory Medical Treatment—Another Step in the State's Expanding Power Over Children?*).

[37] *See e.g.*, Young, at 45.

[38] *Id.* at 44.

[39] *Id.* at 62 (parent drew chalk line on floor and beat children for crossing it).

[40] This view was presented by Dr. David G. Gil, Director of the Nationwide Epidemiologic Study of Child Abuse, Brandeis University, at a seminar at the Johns Hopkins Hospital School of Mental Hygiene, Nov. 27, 1968. All the quotations in this paragraph are from statements made by Dr. Gil.

[41] Dr. Gil told me that while the Brandeis study has not been published in its entirety, parts of it have been published, one such part being a report on child abuse to the National Commission on the Causes and Prevention of Violence.

[42] *See e.g.*, Maryland State Department of Public Welfare, Incidents of Suspected Child Abuse, January-June, 1967, in which it is said, ". . . the authors . . . have decided to forego point by point comparisons with other studies on this subject . . . in those publications available, there are no common definitions, standardized categories or reporting and data collection methods as yet established."

[43] Young at 78, admits that "(b)ehavior so extreme and so bizarre as parental abuse of children might well not be explainable in any simple or ordinary terms." *See also* her Profile of Neglect at 26.

[44] This example was used several times by Dr. Gil at the seminar referred to in Note 40 *supra*.

[45] Stated by Dr. Gil during seminar, Note 40 *supra*.

[46] *Id.*

[47] *See* 124 Amer. J. Psychiat. 10 (1968) (Note, *The Battered Child Rebrutalized: Ten Cases of Medical-Legal Confusion*), and Young at 68 (95% of the parents continued to treat their children abusively despite agency intervention and outside criticism).

[48] *See e.g.*, Helfer & Kempe 128.

[49] Young at 46.

[50] Young at 78 makes reference to this view. *See also* Helfer & Kempe at 109 (Categorical psychiatric diagnoses . . . do not answer the crucial question of why a certain parent abuses children).

[51] *See e.g.*, Helfer & Kempe at 108, 109.

[52] *Id.* at 115.

[53] *Id.* at 113.

[54] *Id.*

[55] *Id.* at 111.

[56] *Id.* at 118.

[57] *Id.* at 119.

[58] *Id.* at 120.

[59] *Id.*

[60] Young at 62 indicates that abusing parents rarely feel the need to explain or justify their behavior but that when pressed, "one of the most common responses (is) that the children wet and soil themselves. Since this is an almost inevitable reaction with children in extreme terror, the parents in effect punished them for what they themselves precipitated."

[61] Abusing parents often express disapproval of their children in terms such as these and worse. *See e.g.*, Young at 51 and Helfer & Kempe at 110.

[62] Young at 68.

[63] *E.g.*, Young at 78 says, "(n)eglect in particular may have been caused by childhood environment in combination with economic and social circumstances. The cause of abuse, however, is not so clear."

[64] *See* Helfer & Kempe at 110.

[65] *Id.* at 108-109.

[66] *Id.* at 126.

[67] *Id.* at 128-129.

[68] *Id.* at 19.

[69] Alverson, *Protecting Children*, Wall Street Journal, July 2, 1965, at 1., col. 6.

[70] 181 J.A.M.A. 42 (1962).

[71] 181 J.A.M.A. 17 (1962).

[72] *See* Note 31, *supra*.

[73] 53 J. of Iowa Med. Society 692 (1963).

[74] 22 Wash. & Lee L. Rev. 182, 186-188 (1965).

[75] *See* Note 42, *supra*.

[76] Helfer & Kempe at 24.

[77] *Id.* at 25.

[78] *Id.* at 28.

[79] This fact has led to a suggestion for preventative measures which would appear to be fraught with serious constitutional and practical difficulties. In 13 Catholic Law 231, 241 (1967) it is proposed that obstetricians be required to "report cases where expectant parents do not appear to want the forthcoming child or where their psychological characteristics indicate the possibility of abuse after the birth of the child. The parents could, if it were found necessary upon an examination, be taught how to be better prepared for the arrival of the child . . . in any event close watch could be kept to see how the parents were adapting to the child."

[80] Helfer & Kempe at 27.

[81] *Id.* at 30.

[82] *Id.* at 31.

[83] 56 Am. J. Roentgen. 163 (1946).

[84] 6 Pediatrics 890 (1950); 63 Am. J. Roentgen. 342 (1950).

[85] 158 J.A.M.A. (1955).

[86] 30 Brit. J. Radiol. 225 (1957); an excellent history of progress in identifying abuse can be found in 50 Minn. L. Rev. 1 (1965).

[87] E. Elmer, *Abused Young Children Seen in Hospitals*, Social Work 98, Oct., 1960; H. Boardman, *A Project to Rescue Children from Inflicted Injuries*, Social Work 43, Jan., 1962.

[88] 181 J.A.M.A. 17 (1962).

[89] *See* Note 92, *infra*.

[90] *See* 22 Wash. & Lee L. Rev. 182, 192 (1965); Helfer & Kempe at 43.

[91] The physician must have a very low threshold of suspicion. Abusing parents, especially those with higher intelligence, often present entirely plausible explanations with regard to the source of the child's injury, *e.g.*, another child inflicted the blow during a quarrel; the child tripped and fell against the radiator; the mother slipped while holding the baby in her arms, etc. . . . *See* Helfer & Kempe at 89.

[92] Listed in 67 Colum. L. Rev. 1, 2-3 (1967); *see also* 50 Minn. L. Rev. 1, 11-13 (1965).

[93] *See e.g.*, 67 Colum. L. Rev. 1 (1967); 44 Denver L. J. 3 (1967); Children's Division, American Humane Association, Part II, Child Protective Services (1967) (hereinafter, Children's Division, Part II).

[94] Children's Division, Part II, 36, 38.

[95] *Id.* at 42.

[96] *Id.* at 51.

[97] *Id.* at 53.

[98] *Id.* at 43.

[99] *Id.* at 35.

[100] *Id.* at 43.

[101] *Id.* at 44.

[102] *Id.* at 48.

[103] *See e.g.*, 67 Colum. L. Rev. 1, 48 (1967); 54 Calif. L. Rev. 1805, 1830 (1966).

[104] *See* 124 Amer. J. Psychiat. 10 (1968); Children's Division, Part I, 3-5.

[105] Children's Division, Part I, 29.

[106] Children's Division, Part II, 49.

[107] *Id.* at 50.

[108] *See* 52 A.B.A.J. 734, 735 (1966); 124 Amer. J. Psychiat. 10 (1968).

[109] 52 A.B.A.J. 223 (1966).

[110] 52 A.B.A.J. 734, 735 (1966).

[111] 50 Minn. L. Rev. 1, 37-8 (1965).

[112] Prosser, Torts, §§109 & 110 at 800-811 (3d ed., 1964).

[113] The privilege was unknown to the common law.

[114] 42 U. Det. L. J. 88 (1964).

[115] *See* Young at 109, 148. *See also In re* Marion Frances, 49 Misc. 2d 372, 267 N.Y.S. 2d 566 (Fam. Ct. 1966).

[116] *Id.* at 142.

[117] *Id.* at 110; *see also* 124 Amer. J. Psychiat. 10 (1968).

[118] *In re* S., 46 Misc. 2d 161, 259 N.Y.S. 2d 165 (Fam. Ct. 1965).

[119] *In re* Young, 50 Misc. 2d 271, 270 N.Y.S. 2d 250 (Fam. Ct. 1966).

[120] *Id.* at 253-4.

[121] *See* Note 79, *supra*.

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PEDIATRICS

Child Abuse Syndrome: A Review

> *"It is as natural to die as to be born; and to a little infant, perhaps, the one is as painful as the other."*
> Francis Bacon
> Essays, 2. *Of Death*

NEGLECT or physical abuse of children has existed throughout recorded history. Yet, only within the past ten years has the medical profession begun to actively recognize and study this clinical entity; and only within the past five years has the medical profession begun to actively report and record this clinical syndrome. Statistics suggest a marked increase in cases of child abuse within the past five years; however, it is doubtful if these statistics reflect anything more than an increased awareness and reporting of cases of child abuse.

In a recent survey by the Child Abuse Research Group of Children's Hospital of the District of Columbia,[1] it was noted that many physicians in that metropolitan area still were not aware of the clinical, legal, and social aspects of the Child Abuse Syndrome (Battered Child Syndrome). Two reasons why this problem exists are that most of the investigative research has been done since 1962 and that much of the research in Child Abuse has been published in social work, legal and other specialized professional journals which the average practicing physician may not see. It is the purpose of this paper to review the literature from all of the disciplines in the hope that such a summary will help to decrease the gap between the results of multi-disciplinary research in this field and the knowledge which is available to the practicing physician. Thus, hopefully the practicing physician will become more alert to the Child Abuse Syndrome and to his role in working with his community in establishing an integrated program for prevention, protection, treatment and assistance for the abused child and the family. The author

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will also attempt to integrate the information from the literature with his own experiences in working with hospital staffs, practicing physicians and representatives from community and private agencies in order to reflect on some of the questions still unanswered.

Definition

It is difficult to define the word "child abuse." The problem lies in deciding which forms of abuse one includes in the definition. The Child Abuse Syndrome represents a spectrum of clinical conditions: at one end of the spectrum would be the malnourished, starving or "failure to thrive" child; at the other end of the spectrum would be the child who has been severely traumatized physically. Some question whether psychological abuse should also be included.

Throughout the spectrum there are many "gray areas" where it is difficult to distinguish between child abuse and parental privilege to discipline. For example, if a parent punishes his child with a belt, is it after the fourth slash with the belt that parental rights end and child abuse begins; is it after the belt raises a welt over two millimeters that it becomes abuse versus parental rights? Would not cultural characteristics influence the differential between parental rights and child abuse? As another example, is refusal to seek medical aid for a child to be considered abuse only after it reaches a point of irreversibility?

Kempe et al[2] defined "The Battered Child Syndrome" as a "clinical condition in young children who have received serious physical abuse . . ." Delsordo,[3] in his study of abused children in Pennsylvania, and Connell[4] in his review of wilful injuries to children, each defined child abuse in terms of violent person-to-child physical assault.

Some authors have attempted to distinguish between child abuse (cruelty) and neglect. Elizabeth Elmer[5] defines abused children as those physically assaulted by adults; neglect is defined as the chronic failure of adults to protect children from obvious physical danger. A joint committee of the British Medical Association and the Magistrates' Association on Cruelty and Neglect to Children[6] attempted to define these terms and concluded, "Cruelty and neglect are not easily definable separately. In general they constitute treatment as the result of which a child's potential development is retarded or completely suppressed by mental, emotional and/or physical suffering produced as the outcome of a deprivation of minimum requirements."

Even if one concentrates on physical abuse, leaving out emotional trauma, a lack of consensus is still apparent. Elmer[7] comments, "It is unclear, for instance, whether chronicity of mistreatment is a necessary condition to establishing abuse. In many families an isolated beating or hard spanking can be expected in the normal course of events. If this is so, how do we label the rare impulsive outburst that results in permanent injury to the child?" Elmer also feels that "ethnic or class identification of the family may determine the judgment about the caretaker's motivation. If the child is poorly dressed or has a skin color different from most of the population's, we may imagine that the caretakers are also different, perhaps abusive . . ."

Some authors have attempted to use a more inclusive definition. Fontana et al[8] feel that "The neglect and abuse of children denotes a situation varying from the deprivation of food, clothing, shelter and parental love to incidents in which children are physically abused and mistreated by an adult, resulting in obvious physical trauma to the child . . ." In addition to the situations mentioned by Fontana, Finberg[9] includes refusal to accept necessary medical advice, neglect of child care leading to accidental ingestion of poisons, self-induced abortion or general personal health abuse on the part of pregnant women resulting in prematurely born infants, and prenatal neglect of children. Delaney[10] defines child abuse as "any injury to the child's good health through physical violence, gross neglect or parental ignorance or unconcern. A child is physically abused if a parent willfully physically injures him; a child is physically abused if through parental neglect he is not fed and becomes malnourished; a child is physically abused if through parental neglect or unconcern in providing a protective environment, he suffers physical injuries; a child is emotionally abused if physical cruelty is allowed to continue; a child is intellectually abused if, as a result of his physical injuries, he suffers permanent brain damage . . . a child (is) . . . emotionally abused if he does not receive the affection and guidance of his parents . . ."

The most workable research definition includes all aspects of abuse—physical, emotional, and social. It is for this reason that the author prefers the term "Child Abuse Syndrome" to the term Battered Child Syndrome. However, from the legal aspect, the concepts of emotional and social abuse are too vague to be useful. Most child abuse laws refer to neglect of children but focus primarily on physical abuse. Perhaps, as psychiatrists and social scientists better understand and define emotional and social neglect and abuse, the legal professions can begin to incorporate such concepts into the laws.

Scope

We have no accurate picture of the incidence of child abuse; however, the data from several recent surveys suggests that the number of cases in the United States is between 200,000 and 250,000 children each year.[11] There are several reasons why accurate statistics are difficult to obtain: (1) there are differing definitions of abuse; (2) there are cases of abuse which may not come to the attention of medical personnel; (3) there are cases of abuse which are brought to medical attention but which may not be suspected or diagnosed as child abuse; (4) there are cases which may be suspected but not reported by physicians.

Kempe et al[2] did the first nationwide survey in 1962. In a review of 71 hospitals he learned of 302 cases of "Battered Child Syndrome" (33 of whom died, 85 of whom received permanent injury). Kempe and his group emphasized the prevalence of the problem and felt that their statistics were not a total reflection of the problem in this country. In the same year Jacobziner[12] of the New York City Department of Health noted that about 4,000 cases of child neglect came to the attention of the city's courts. Kempe's survey alerted hospitals to look for possible cases of child abuse; one hospital in his survey reported no known cases of Battered Child Syndrome; yet, a year later the same hospital reported over 50 cases of child abuse.

Chesser,[13] in reporting on the work of England's National Society for the Prevention of Cruelty to Children, concluded that between six and seven percent of all children are some time during their life "so neglected or ill-treated or become so maladjusted as to require the help of the National Society for the Prevention of Cruelty to Children." A 1964 study in California suggested a minimum of approximately 20,000 children in need of protective services in their state alone.[14] In 1958 the American Public Welfare Association reported approximately 100 cases referred monthly to the Public Welfare Department of Denver, Colorado, for protective services. Zalba,[1] extrapolating on the basis of the data from California and Colorado, gives a conservative estimate that there are between 200,000 and 250,000 children in the United States needing protective services each year.

One can but wonder what the statistics would show if all cases of child abuse were brought to medical attention, diagnosed and reported. Fontana[16] states that "If statistics were complete and available, the maltreatment syndrome could turn out to be the most common cause of death in children."

History

The first recorded case of gross child abuse occurred in New York City in April 1874 and involved a nine-year-old child, Mary Ellen.[17] A nurse brought this child to the attention of the American Society for Prevention of Cruelty to Animals. No society for the prevention of cruelty to children existed in those days.

As early as 1888, West[18] presented cases of what he called "acute periosteal swelling in infancy" that improved spontaneously and could not be identified with any known disease entity. In 1907, Stone,[19] after observing unexplained sub-periosteal elevation on several X-rays, suggested that perhaps there were many injuries to bones which pass unrecognized clinically. Thirty years later, in 1937, Snedcor et al[20] observed that these same changes which they called "traumatic ossifying periostitis" could occur in newborns delivered from a breach position. They postulated that excessive traction and torsion of the legs during delivery frequently fractured or stripped the periosteum from the shaft of long bones with resultant sub-periosteal hemorrhage. In 1946, Caffey[21] emphasized frequent association of clinical subdural hematoma and fracture of long bones; he was unable to obtain a history of violence and drew no conclusions as to etiology. In addition, Caffey noted the frequency with which defects in the metaphyses as contrasted to the shafts of bones were encountered. In 1950, Smith[22] and later Frauenberger and Lis,[23] reported spontaneous multiple fractures associated with subdural hematomas in infants who were not thought to have been injured. Astley,[24] in 1953, described six babies with metaphyseal discontinuity of bone similar to that described by Caffey. Astley called this "metaphyseal fragility of bones." Despite coincidal presence of retinal separation, easy bruising, black eyes, compressed vertebrae, and other injuries only remotely related to a hypothetical metaphyseal fragility, Astley maintained the concept of a separate entity. In 1953, Silverman[25] reported on "unrecognized skeletal trauma in infants." He was the first to describe completely the clinical syndrome as we now know it and to relate the metaphyseal fragmentation and cortical changes seen on X-ray to traumatic episodes which were not always described in the history as given by the parents. In 1935, Woolley and Evans[26] pointed out that the three different syndromes described by Caffey, Silverman, and Astley were variations of the same basic process of repeated trauma despite the presence or absence of a history of trauma; they emphasized some of the sociologic and psychiatric aspects of the problem of wilful trauma to children. These authors felt that the bone changes represented accumulations rather than single isolated events. In 1957, Caffey[27] reviewed his previous work and agreed with Woolley and Evans that what he had been describing as a syndrome of subdural hematoma and bone changes was perhaps really unsuspected trauma. Caffey pointed out that when the X-ray findings were pathognomonic of suspected trauma (lesions in several different stages of development) the radiologists should not be misled by inadequate or misleading historical and clinical data.

In 1961, a symposium on the Battered Child Syndrome was held by the American Academy of Pediatrics.[28] This symposium brought into focus the increasing professional recognition of the problem. In 1962, Kempe et al[2] presented evidence of the prevalence of the syndrome and alerted physicians to consider this diagnosis and to be aware of their duty and responsibility to the child. Since 1962, numerous articles have been published on the incidence, clinical manifestations, social and psychological characteristics of both the battered child and the battering parent, and the physician's responsibilities.[29]

General Characteristics

When attempting to find general characteristics in child abuse cases, one must keep in mind that complete statistical data for this syndrome do not yet exist; therefore, reliable conclusions cannot be made. However, based on available knowledge some generalizations can be made.

Although child abuse can be found at any age, Kempe et al[2] noted that the abused child is usually younger than three years. In the hospital studies of Elmer,[3] the children were very young, with over half of the sample being under one year of age. Elmer also noted that the largest group in her study was under three months of age when multiple bone injuries were found; the next largest group was from three to six months. She noted the contrast in her findings to the curve for incidence of childhood accidents, which shows that the incidence rate for accidents in children is minimal below the age of nine months. Boardman[30] and McHenry et al[31] also noted that the majority of the abused children in their groups were under one year of age. In contrast, Bryant et al,[32] Merrill,[13] and Delsordo[33] noted that in their studies the children were older, with half the children under seven years of age.

Usually one child in a family is selected to be abused. In an agency study, Merrill[13] observed that once the abuse had begun, there was a tendency for the abuse by this parent to become repetitive toward the selected child. Zalba[11] feels that the one child chosen as the target of abuse is frequently that child who was conceived or born extramaritally or premaritally. Because in almost all cases only one child is the victim, Boardman[30] believes that the child has become a symbol of some kind to the adult, and the adult's controls are so tenuous that periodically his anger explodes against the "symbol." Why one particular child is selected and what family pathology the child might represent are unanswered questions. As Milowe[34] describes it, "The parent's childhood loads the gun; present life conflicts cause the parent to raise it; the child's phase-specific needs help pull the trigger."

One parent is usually the active batterer and the other parent passively accepts the battering; the passive parent may do so because the battering of the child diverts a conflict which this parent does not wish to become involved in or because this parent feels too weak or inadequate to interfere. In Boardman's[30] study, only one mother in thirty-one cases voluntarily changed the environment because of apparent primary concern for the child; most of the adults immediately involved invariably protected each other, ignoring the child's need of protection. The abusers were usually the child's own parents with whom they were currently living; mothers and fathers were identified as the abusers in equal numbers of cases.[3, 13, 32, 33]

In one study by De Francis,[35] fathers were responsible for 38.25 percent of injuries in the

662 cases reported. Mothers inflicted injuries in 28.86 percent of the cases. Mothers inflicted more serious injuries and were responsible for more fatalities. Parents were responsible for 72.57 percent of all injuries inflicted. Three out of four of all children who died, died at the hands of one or both parents.

Types of Abuse

Physical abuse by acts of commission may take many forms. The abusers in Young's study "assaulted their children; they beat them with ironing cords, wires, sticks, even pieces of lead pipe. Some slammed them into a wall. The scars and cuts on the children's bodies, the broken bones were mute witnesses of this brutality."[36] Young also describes cases of physical torture: parents burned their children with lighted cigarettes, scalding water, hot stoves; parents knocked their children down with their fists; some parents bent back their child's fingers or twisted his arms, occasionally until the arm broke; other parents bit their children. Destruction of loved pets, often in front of the child, was also noted.

Frequently, what appears to be an unrelated clinical condition can, following investigation, be found to be a case of child abuse. Dine[37] reports a case of a 19-month-old who was admitted to the hospital on several occasions over a brief period of time with the presenting problems of hyperpyrexia, prolonged sleep, convulsion and extrapyramidal signs. On each occasion the signs disappeared by the second or third day in the hospital. Investigation finally revealed that the mother had been feeding the child perphenazine (Trilafon) which had been prescribed for her. Eisenstein et al[38] report a case of intestinal obstruction due to an intramural hematoma of the jejunum which proved to be the result of trauma. They reviewed 11 other cases of intramural hematoma from the literature and raised the question of possible wilful parental abuse as a possible etiology.

Adelson,[39, 40] reports numerous cases of homicide which he feels were variants of the Battered Child Syndrome. In another article, Adelson[41] emphasizes the acts of omission whereby the child is deprived of adequate nutrition. He feels that these acts of omission are equally dangerous to the child's welfare and that, because this type of maltreatment is more subtle and covert, it is more difficult to discover, diagnose and rectify.

Physical Diagnosis

HISTORY

In obtaining a clinical history from the family, one frequently, if not consistently, finds a contrast between the history given and the clinical findings observed. For example, a mother might state that a child rolled over in its crib and in so doing broke its arm or fractured its skull. One usually elicits a negative history of trauma. Failure to obtain a satisfactory explanation of fractures, subdural hematoma, failure to thrive, soft tissue swellings, bruising or sudden death, should alert the examining physician to seriously consider the possibility of child abuse. Although history of injury to smaller children may frequently be withheld by their parents and others deliberately, in some cases and inadvertently in others, the history is negative for trauma because the informant is unaware that the child has been injured; e.g., if the child was injured by someone else, or out of the parents' presence. Older children who have been injured may not mention or may deny the trauma in the interest of avoiding punishment.

Caffey[42] comments, "The pediatrician supposes that he will be given the full and honest history about all aspects of the child, including trauma, and he passes it by unless it is presented to him voluntarily." He feels that "This erroneous supposition by the physician is one of the important deterrents to early accurate diagnosis of infantile and juvenile injuries and abuse."

PHYSICAL SIGNS

Any one or all of the signs of soft tissue or bone disease may be observed: abrasions, contusions with petechiae and ecchymoses, warm or swollen areas, extremity with pain and tenderness, decreased voluntary movement, limping or failure to bear weight. The swellings may be single or multiple and in the case of repeated injuries, the swellings are found in different stages of evolution and involution. Fever is rarely noted except when it reflects a secondary complication of the battering (e.g., internal bleeding). One may find associated evidence of trauma: hematuria, shock, vomiting, ataxia, impaired vision, ruptured viscera, subdural hematoma, retinal hemorrhage or detached retina. Frequently the evaluation will show signs of trauma at various stages of healing: bruising, swelling, fractures. One may also find previous evidence of trauma: burns, scars, deformities. In some younger children one will find suggestions of failure to thrive where evaluation fails to reveal a metabolic or infectious etiology.

It is to be remembered that the degree of injury is not necessarily related to the traumatic event. A child may fall several flights without major injury. Other children may develop severe subdural hematomas after falls of two or three feet.

LABORATORY

Laboratory evaluations can not specifically identify traumatic lesions or rule out the other clinical conditions being considered in the differential diagnosis. The traumatic origin of blood in the cerebro-spinal fluid, the pleural, peritoneal, and pericardial fluids, nasal discharge, sputum, urine, or feces is obvious with a history of trauma. The same findings, however, in the absence of history of trauma, are not diagnostic of trauma but raise the question of other causes. Biopsy specimens taken from traumatic lesions have only negative diagnostic value. Biopsy specimens taken from growing bones have been misleading in some cases of trauma because the presence of substantial amounts of mitotic figures have suggested neoplasm, rather than trauma, to the microscopist.

RADIOLOGY

Caffey[42] notes that "in most tissues of the body, radiologic findings do not differentiate traumatic changes from nontraumatic ones. The great exceptions to this statement are growing bones, which, when traumatized, may disclose conclusive evidence of the trauma in the absence of fractures and dislocations." One frequently finds metaphyseal fractures, especially at the periphery. These fractures result from violence exerted about the joints. One may find small fragments of bone actually torn with their attached ligamentous fibers from the metaphysis (chip fractures). In early childhood, one may find epiphyseal injury. In some cases one may find long bone periosteal proliferation (traumatic involucrums) which is apparently unexplained by the clinical history. LoPresti[43] notes, "There is a paucity of Sharpey's fibers and the periosteum is loosely attached to the shaft of the bone. In addition, the infantile periosteum is highly vascular and firmly anchored to the metaphyses by dense fibrous extensions. As a result, a small avulsion fracture of the metaphysis may produce a large subperiosteal hemorrhage. In approximately two weeks, as this hemorrhage is absorbed, the elevated periosteum lays down new bone and a bizarre cortical hyperostosis is produced." Since hypervitaminosis, infantile cortical hyperostoses, syphilis, scurvy and bone tumors are far less frequently the cause of periosteal new bone formation, trauma should always be first among the diagnostic considerations. The metaphyseal infractions have special diagnostic value because they appear immediately and are, therefore, immediately diagnostic when early films are made. The traumatic involucrums usually do not appear before the eighth or the tenth day after injury. They have special diagnostic value; when they are present in different stages of development, they indicate recurrent traumatic episodes or multiple beatings of the child. Caffey[42] feels that "The presence of these metaphyseal infractions and traumatic involucrums in otherwise normal bones are diagnostic of trauma in themselves, even in the absence of history of trauma."

Evidence of skeletal trauma at different stages of healing is common. For example, overt fractures may be present in other bones; there may be abundant and active but well-calsified subperiosteal reactions with widening from the shaft towards one end of the bone; one or more bones may demonstrate distinctly thickened corticies, residuals or previously healed periosteal reactions.

Skull fractures and subdural hematoma are frequently associated with purposeful injury; thus, if one finds fractures of long bones, especially involving the metaphysis, one should survey the other bones and obtain films of the skull. Conversely, if one finds a skull fracture in a child, one should consider doing a long bone survey.

In the 1965 Howland Award Address, Caffey[42] warned that "Even classical radiographic changes of trauma in the bones tell nothing of the person who abused the child or how it was abused. Radiographic changes alone, therefore, never warrant the accusation by the radiologist, pediatrician, or social worker that a specific person or persons are responsible for the injury . . . the radiologist, however, can always state with full confidence that the child has suffered from mechanical injury when these telltale radiographic changes are present, even in the absence of a history of trauma."

DIFFERENTIAL DIAGNOSIS

When the history of injury is clear, the signs of trauma are immediately attributed by the doctor to injury. However, these same clinical signs, in the absence of history of injury, become deep diagnostic puzzles for they raise the question of all of the nontraumatic diseases which produce physical signs. Fever is common after internal bleeding and, falsely, this may suggest infections. Convulsions which follow known injury are immediately attributed to subdural hematoma or cerebral lacerations but the same convulsions, in the absence of history of injury, suggest first brain tumor or, in the case of associated fever, some kind of meningoencephalitis.

Scurvy also produces large calcifying subperiosteal hemorrhages due to trauma; however, scurvy is a systematic disease in which all of the bones show the generalized osteoporosis associated with the disease. Vitamin C content of the blood is normal with abused children.

Syphilis in the first months of life can result in metaphyseal and periosteal lesions similar to those under discussion; however, the bone lesions of syphilis tend to be symmetrical and are usually accompanied by other stigmata of the disease. Multiple lytic areas are often seen. The STS is useful in establishing this diagnosis.

Osteogenesis imperfecta also has bony changes which may be confused with those due to trauma; but, it too is a generalized disease and evidence of the disorder should be present in the bones other than those traumatized. Even in skull fractures, the mosaic ossification pattern of the cranial vault, characteristic of osteogenesis imperfecta, is not seen in abused children. Fractures of osteogenesis imperfecta are commonly of the shafts; in the abused child it is in the metaphyseal regions. Blue sclerae, skeletal deformities and family history will assist in establishing the diagnosis.

Infantile cortical hyperostosis produces diaphyseal lesions; however, the metaphyseal lesions of unrecognized trauma serve to differentiate the two conditions. The characteristic mandibular involvement of infantile cortical hyperostosis does not occur following trauma, although an obvious mandibular fracture may be produced.

Pyogenic osteomyelitis usually produces frank bone destruction with involucrum and sequestrum formation; these are not seen in unsuspected trauma.

Tuberculosis of bone also is destructive. The tuberculin test helps to differentiate this disease.

Leukemia and metastatic neoplasms bear no resemblance to unsuspected trauma. *Primary bone neoplasms* are almost unheard of in this age group.

Other disease processes which produce bone changes may be considered: blood dyscrasia, rickets, congenital hip disease, poliomyelitis. Laboratory studies assist in differentiating these entities.

The radiologic manifestations of trauma are specific. The metaphyseal lesions, in particular, occur in no other known disease. Gwinn[44] feels that "The presence of traumatic changes in several locations and in different stages of healing is indicative of repeated episodes of trauma and is a *sine qua non* for the roentgenographic diagnosis."

DANGERS OF PHYSICAL DIAGNOSIS

The danger in establishing the diagnosis of child abuse is in making an incorrect diagnosis. The major emphasis has been in being alert to the possibility of willful injury; but, the problem of missing a case of child abuse is equally matched by the danger of incorrectly labeling a case of child abuse. A child, after an ordinary slap or push by a parent, bent on only normal punishment, may be propelled against the sharp edge of a table or bed and this secondary injury which the parent did not intend may induce fatal laceration of the liver, spleen, or brain, or tear the communicating veins to produce fatal subdural bleeding. The use of reasonable and usually safe force in the punishment of a child by parents may produce unintentional secondary injuries which are serious and sometimes fatal; and the innocent parent may suddenly find himself in the toils of the law charged with child abuse or even murder when he actually set out to correct the child by moderate or mild punishment.

In some cases the difficulty is in determining what is reasonable and safe punishment; this is a legal issue still to be resolved.

Psychological Characteristics

THE FAMILY

Parents who inflict physical abuse on their children are not necessarily from the lower socioeconomic classes. Many are middle class and self-supporting, with well-kept homes. Merrill[13] observed that the majority of the 115 families in his study had lived in their communities for years and had not moved about extensively. These families did not show great integration in their communities, as evidenced by few group associations. The families were found to be not fully accepted within their communities. Ninety percent of the families were found to have serious social problems, marital discord, financial difficulty, other family conflicts, faulty community relationships. In slightly less than 50 percent of the families, premarital conception had occurred. These families had many problems at the time of marriage and by the time the abuse occurred, these problems had multiplied and intensified. In a study at Children's Hospital of Pittsburgh,[31] certain general family characteristics were observed: (1) the adults showed impulsive behavior in areas other than child care; (2) the marital histories revealed an unusual degree of instability, some parents had never been legally married or, if married, divorce or separation was common; and (3) where information was available, the adults had been subjected in early life to emotional deprivations, such as extreme rejection or overt hostility.

THE ABUSING PARENT

Merrill[33] noted three distinct clusters of personality characteristics in the parents studied. The first group showed characteristics of hostility and aggressiveness, with the appearance of being continually angry at someone or something. This was not a controlled anger and was continually with them. The angry feelings seemed to stem from conflicts within the mothers themselves, and with the only stimulation needed for a direct expression of this being the normal difficulties most mothers experience daily. The second group could be identified by personality characteristics of rigidity, compulsiveness and lack of warmth. There were marked child rejection attitudes among many mothers in this group; this was evidenced by their primary concern with their own pleasures and by inability to feel love and protectiveness toward their children. A third group of parents showed strong feelings of passivity and dependency. These parents competed with their children for the love and attention of their spouses. Merrill also noted a group which included a significant number of abusing fathers who were fully or partially unable to support their families due to a physical disability of some degree. In most of these situations the mothers were supporting and the fathers stayed at home acting as a mother figure.

Morris and Gould[45] feel that the neglecting or battering parent is involved in role reversals involving many roles. They note: "To the current parent, the child appears as the original parent in all that parent's malign, primitive meanings and blighted hopes . . . From birth, babies are perceived by these parents as having adult powers for deliberately displeasing or judging and appear to be as unsatisfying and unsatisfiable to the current parent as were their original parents. The natural dependency of babies reinforces the projected image of the original parents who demanded, who could not be satisfied, and who did not satisfy the current parent."

Morris et al[46] compare the typical reactions and attitudes of protective parents to children's injuries with the typical reactions and attitudes of neglecting, battering parents. In so doing they offer useful general guides one might use in evaluating parents of suspected child abuse cases. The typical reactions and attitudes of protective parents to children's injuries are noted to be: (1) voluble and spontaneous in reporting details of a child's illness or injury; (2) show concern about the degree of the damage; (3) show concern about treatment; (4) show concern about the possibility of residual damage; (5) exhibit a sense of guilt; this guilt and remorse is frequently found even when the parent has had no part in the child's injury; (6) ask many questions regarding the prognosis of the child's condition; (7) have difficulty in detaching from the child on admission; (8) attempt restitution through frequent visits, toys, gifts and apologies to the child; (9) ask questions about discharge date; (10) ask questions regarding follow-up care; (11) identify with the child's feelings, both physical and emotional; (12) are positively related to the child. Typical attitudes and reactions of neglecting, battering parents are noted to be: (1) do not volunteer information about the child's illness or injury; (2) are evasive or contradict themselves regarding the circumstances under which the child's condition occurred; (3) show irritation at being asked about the development of the child's symptoms; (4) are critical of the child and angry with him for being injured; (5) give no indications of feeling guilt or remorse regarding the child's condition; (6) show no concern about the injury; (7) show no concern about the treatment; (8) show no concern about the prognosis; (9) often disappear from the hospital during examination or shortly after admission; (10) tend not to visit the child in the hospital; (11) seldom touch the child or look at the child; (12) do not involve themselves in the child's care in the hospital; (13) do not inquire about the discharge date; (14) do not ask about follow-up care; (15) act as though the child's injuries are an assault on them; (16) fail to respond to the child or respond inappropriately; (17) give no indication of having any perception of how a child could feel physically or emotionally; and (18) consistently criticize the child.

THE ABUSED CHILD

Milowe and Lourie[47] feel that in some cases of child abuse, defects in the child can act as a precipitating factor, particularly those defects which lead to lack of responsiveness or other irritating reactions creating frustration in the parent. They also feel that there might be factors in the personality development of some children leading to the child's inviting others to hurt him or to hurting himself, i.e., a "hurt and be hurt" relationship pattern. In another report, Milowe[illegible] notes that a small percentage of abused children are atypically difficult, are irritating children, some with a particularly grating quality to the crying. He also notes that some of these children get battered in sequential foster home placements where no other child has ever been battered.

Morris et al[46] compare some typical forms of behavior of well-nurtured children in a hospital with some typical forms of behavior of neglected and battered children in the hospital. As with the comparison of parents, the differences are useful general guides one might use in evaluating suspected child abuse cases. Typical forms of behavior of well-nurtured children in the hospital are noted to be: (1) cling to parents when they are brought in; (2) turn to their parents for assurance; (3) turn to their parents for comfort during and after examination and treatment; (4) consistently show by words and action that they want their parents and want to go home; (5) are reassured by their parents' visits. Typical forms of behavior of neglected and battered children in the hospital are noted to be: (1) cry hopelessly under treatment and examination; (2) cry very little in general; (3) do not look to parents for assurance; (4) show no real expectation of being comforted; (5) are wary of physical contact initiated by parents or anyone else; (6) are apprehensive when other children cry and watch them with curiosity; (7) become apprehensive when adults approach some other crying child; (8) seem to seek safety in sizing up the situation, rather than in their parents; (9) are consistently on the alert for danger; (10) are consistently asking in words and through their actions what will happen next; (11) ask, "When am I going home?" or announce, "I'm not going home," rather than crying "I want to go home;" (12) assume a flat "poker face" when discharged home or when discharge is mentioned.

THE PHYSICIAN

Kempe et al[2] note that "Physicians have great difficulty both in believing that parents could have attacked their children and in undertaking the essential questioning of parents on this subject. Many physicians find it hard to believe that such an attack could have occurred and they attempt to obliterate such suspicion from their minds, even in the face of obvious circumstantial evidence." The author,[1] in surveying the physicians in one metropolitan area during 1966, noted that one in five physicians surveyed reported that they rarely or never considered child abuse on seeing an injured child. In addition, the survey revealed that one in six physicians mistakenly had not considered child abuse in cases that they had seen in the past; one in two physicians did not know the correct procedure to follow in their community; one in three physicians did not know what follow-up procedures were used; and one in four physicians stated that they would not report a case of suspected Child Abuse Syndrome even with legal protection. These physicians were concerned that their evidence would not stand up in court, that the legal time lost in court proceedings was too lengthy, or that there were implications to their practice by reporting a suspected case. In general, this survey suggests that some physicians have difficulty admitting that such an entity could exist and hesitate to follow through on a suspicion of child abuse. The study also suggests that many physicians do not report a suspected case of child abuse because of past experience or frustrations encountered when dealing with community or legal agencies.

Consequences of Child Abuse

One of the most critical consequences of child abuse is that if the case is not suspected and reported and if the community follow-up is not initiated, the child may return with recurrent injuries, perhaps finally coming to a hospital dead on arrival or dying shortly after admission. In addition, a large percentage of the children become lame, mentally retarded, blind or show other evidence of permanent physical damage. In a survey by Elmer[3] of 50 cases of abused children, seven died and seven received serious physical defects of whom four were permanently crippled.

Of equal concern is the psychological consequence of child abuse. The manner in which the physical abuse will be reflected psychologically depends on the child's emotional makeup, the age at the time of the abuse, the resources of the child (psychological defenses and restitutive ability), and other factors not yet clearly investigated. Curtis[48] expressed concern that "the probable tendency of children so treated (is) to become tomorrow's murderers and perpetrators of other crimes of violence, if they survive." Curtis theorized that children so treated should have an unusual degree of hostility toward parents and toward the world in general. The controlled channeling of this hostility into nondestructive avenues of release would pose a problem both for the child and for society. In addition, the child would be presented with parental objects for identification who provided an example of the destructive and relatively uncontrolled release of hostile aggression. Duncan et al[49] studied six male adult prisoners convicted of first degree murder; all were of middle class families of good social standing. Four case histories showed continuous remorseless brutality suffered during childhood at the hands of one parent in the face of compliant acquiescence of the other. The re-among two prisoners were overtly psychotic and no childhood history was available. Easson and Steinhilber studied eight boys who had made murderous assaults; in two cases there was a clear history of habitual brutal beating by a parent and in three cases there was a suspected history of abuse.

Although the child who comes to the hospital dead or who dies shortly after admission creates the most attention in the medical and lay press, there are many more children who leave the hospital with physical disabilities or residual mental retardation and others who leave the hospital with psychological disabilities which may restrict the child's development and may lead him to become the battering parent of tomorrow. By treating the syndrome as soon as it is suspected, one not only prevents possible permanent injury or death of the child, but one also may break the "violence breeds violence" cycle.

Child Abuse Laws

As of June 1, 1967, 50 states, the Virgin Islands and the District of Columbia have statutes on child abuse, with legislation pending in Puerto Rico. In 1962, the Children's Division of the American Humane Society initiated a study of the child abuse problem in America. Based on the findings of the study, an Advisory Committee to the Children's Division endorsed mandatory reporting of suspected inflicted injuries on children. In 1963, the Children's Bureau of the Department of Health, Education and Welfare proposed model legislation on reporting the case of the physically abused child. This model act has several basic features: (1) it recommends reporting by physicians or institutions of any case in which there is reasonable cause to suspect a battered child; (2) it suggests procedures for this reporting; (3) it provides immunity from liability for the physician; (4) it establishes that neither the physician-patient privilege or the husband-wife privilege can be a ground for excluding evidence if the court so chooses; (5) it states that anyone not reporting a suspected case of a battered child would be guilty of a misdemeanor. Many states in addition have initiated a central registry by which any patient suspected of child abuse is recorded on a file which is available to every physician. This central registry helps to pick up those children who are brought to different hospitals or different physicians with each injury and, therefore, are not picked up as recurrent child abuse cases.

From the beginning, the medical, legal and social work professions have been concerned with the effectiveness of such a law. Rinehart and Elmer feel that the law's concentration on the one child seen by the doctor failed to mention possible dangers to other children in the household. In addition, they emphasized concern that the law might increase hazards for the injured child in that the publicity accorded in a mandatory reporting law could result in fewer injured children being brought to the doctor. Finally, they questioned the soundness of the suggested language of the law which appeared to recommend the police as the appropriate agency to receive reports of the alleged child abuse.

The General Counsel of the American Medical Association expressed concern over the new legislation in April, 1964. The major concerns noted were (1) that legislation should infer immunity from litigation and damage, not only on physicians, but also on lawyers, nurses, social workers, and others who seek to protect abused children by reporting; (2) that compelling the physician alone to report singles him out unwisely or causes the parent or guardian, for his own protection, to put off seeking medical care; and (3) that mandatory reporting in and of itself will not eradicate undesirable social conduct. The Committee on the Infant and Pre-School Child of the American Academy of Pediatrics recently stated, "Mandatory reporting by physicians of suspected cases of child abuse is justified and that legislation for this purpose should be primarily of a protective rather than a punitive nature."[34]

There is concern that publicity on child abuse and the mandatory reporting laws could have a negative effect. Parents who accidentally injure their child or who do not know how an injury occurred might delay or avoid seeking medical help for fear that they will be labeled "child abusers."

Paulson[35] reviewed the legislative history of the child abuse reporting laws and expressed concerns about the future:

> "Many supporters of child abuse reporting legislation viewed enactment as a means of strengthening the network of child protective services. The services are needed, but are by no means universally available . . . Existing statutes will require additional appropriations for expanding children protective services (for) as child abuse reporting legislation (becomes) effective, it will add to the existing overburdened case load of the agencies."

He concluded, "To be a wise program for action, it should evolve on a solid basis of medical, psychiatric and social research. Legislation should be formulated only after proposals are fully examined by a partnership of individuals, voluntary associations and state government." Paulson,[36] in a study of the legal protections against child abuse, again expressed concern with reporting laws:

> "Reporting is, of course, not enough. After a report is made, something has to happen. A multidisciplinary network of protection needs to be developed in each community to implement the good intentions of the law. . . . The legislatures which require reporting but do not provide the means for further protective action delude themselves and neglect children."

The author[1] following a survey of physicians in one metropolitan area, concluded that, "Methods of communication from medical professional organizations and from government and community agencies have not been completely effective in familiarizing the physicians in the metropolitan area with the battered child syndrome or with the community procedures to be used for reporting. Child abuse laws will not be enough until these lines of communication are improved. There are several areas of resistance which inhibit some physicians from reporting suspected cases of child abuse. A need exists to further educate physicians, to clarify many basic terms and concepts and to define the responsibility and limitations of the individuals and agencies involved in cases of child abuse (e.g., physician, child welfare agency, child protective service, police, juvenile court and criminal court)."

Community Procedures

In general there are three different types of community approaches to the problem of child abuse in this country. The protective services program involves a social service representative who goes to the family of the child suspected of abuse and evaluates the situation offering what assistance might be needed. The social agency representative says, in essence, to the family, "Your child has been injured. This suggests that there is a family difficulty. May we be of help to you in working out the family problem?" If the child is in danger, the social agency representative may obtain a court action to remove the child from the family;

however, the major emphasis is in helping the family and not in penalizing the parent. In some cases time is lost in obtaining a court action, time which sometimes proves fatal to the child.

Another community approach operates through the police department. Here, a representative of this department investigates the family first. Although the officer is interested in evaluating the situation and protecting the child, the uniform or police badge may make the parents defensive and often may result in their being less receptive to social service assistance at a later date. The police department, after its evaluation, may directly remove the child or may require a court order, depending on the community procedure. Social service agency participation may also be requested. Since the police department is the only 24-hour service available in all communities, the model laws have recommended the police as the best reporting agent.[illegible]

A third approach is the combined use of police and social service agency personnel in which representatives from each go to the home together, each evaluating his particular area of concern; however, each presenting himself as a representative of the community who wishes to help the family with its difficulties.

The author feels that the best approach is a form of the social service approach in which the major goals are to protect the child and to assist the family in making use of whatever community facilities it may need. After evaluating the parent or parents, appropriate action can be initiated. Some parents may need social or psychiatric help, some parents may need hospitalization, other parents may need criminal court action. Penalizing the parent or placing the parent in jail does not help the problem; in fact, in many cases it may complicate the problem by depriving the family of the wage earner or by removing the mother, thus creating even greater disruptions of family life and creating the need for a variety of community services, such as public assistance, foster home placement, homemaker service or other supportive measures. It is felt that the first task is to protect the child. Following this the major emphasis should be in helping to minimize the family or intrapsychic stress which created the battering need. By offering help and not prosecution, the parents will be more available to look at the family difficulties and to accept community assistance in coping with the difficulties.

Regardless of the community approach, problems exist in defining terms, in determining the role of community agencies, and in deciding when a community agency should intervene in a family crisis.

Cheney,[illegible] in discussing the legal problems of providing protective services, focuses on such problems. He questions the definition of "neglect":

> "Neglect" . . . is a concept which permits no degree of certainty, either in legal definitions or social application . . . Most neglect statutes . . . define the conditions on which the State may act (using) standards (that) do no more than import vague subjective tests into a legal criterion.

He also questions the spectrum of clinical or social situations which could fit within certain basic definitions, and he wonders where professional groups should draw the line. For example, at what degree of family deterioration is intervention by a social agency to take place? Cheney raises the question of the possible continuum of situations in which the term "neglect" could be used. Is emotional and social neglect the same as physical neglect? He feels that before emotional and social neglect can be dealt with as is physical neglect, psychiatrists need better to delineate standards of psychological welfare. As he notes, "The need for action in behalf of emotionally disturbed children is difficult to translate into legal standards because the medical guidelines themselves are uncertain." In the same discussion, Cheney notes that there are almost no written juvenile court opinions dealing with neglect, and few appellate decisions. Thus, a child-protective service worker, in determining whether to refer a case to court, must rely on his personal or hearsay knowledge of what the judge has done in the past.

Each physician must familiarize himself with the procedures in his community for handling child abuse cases. If no procedures currently exist, he needs to encourage his community to establish such procedures. In addition, each physician must decide how he will handle cases of child abuse.

The Committee on Infant and Pre-school Child of the American Academy of Pediatrics feels that the practicing physician might be handicapped when encountering a case of suspected maltreatment in his office practice because of the traditional physician-patient relationship, and because of the lack of time for obtaining an accurate history.[84] Also, it is suggested by this committee that the physician may lack laboratory facilities, X-ray, etc., to make a suitable evaluation. They recommend that the physician hospitalize the child for such an evaluation.

The willingness of hospitals to accept the challenge presented by the Committee on Infant and Pre-school Child of the American Academy of Pediatrics in suggesting to physicians that they depend on the hospital for medical evaluation, diagnosis and disposition in cases of child abuse has not been fully explored. There is no question that such a diagnostic evaluation would be more complete, would support the private physician in his role with the family, and would minimize the involvement of the private physician in legal suits or time lost in legal actions.

Conclusions

That the Child Abuse Syndrome exists and exists to a greater degree than current statistics show cannot be denied. Legislation making child abuse a reportable public health concern is necessary. Community programs to deal with cases of child abuse with a protective, assistance-oriented approach rather than with a punitive approach are necessary. However, the physician is the central person in the child abuse problem; he must be alert to the possibility of the Child Abuse Syndrome. After making this diagnosis, he needs not only to treat the medical pathology but to assist in treating the social pathology.

The purpose of this paper has been to review the literature from all of the disciplines in the hope that such a summary will assist the practicing physician to become more alert to the Child Abuse Syndrome and to his role in working with his community. In addition, the author has attempted to integrate the information from the literature with his own experiences in working with hospital staffs, practicing physicians and representatives from community and private agencies in order to illustrate some of the questions still unanswered.

The medical profession must spearhead the efforts of those individuals and groups concerned with the child abuse problem with the ultimate goal of an integrated program for prevention, protection and assistance for the abused child and the family.

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UNIT VI

Child Maltreatment: Help and Hope

VI. CHILD MALTREATMENT: HELP AND HOPE

--- What Can Be Done About It?

UNIT VI. CHILD MALTREATMENT: HELP AND HOPE

Instructional Objective One for Generalizations A and B

THE STUDENT WILL BE ABLE TO RECOMMEND RESPONSES TO THE PROBLEM OF CHILD MALTREATMENT WHICH PROVIDE HELP FOR BOTH THE CHILD AND THE CARETAKER.

Generalizations for Unit VI.

A. Through the individual's response to the problem of child maltreatment, there is help for the maltreated child.

B. Through the individual's response to the problem of child maltreatment, there is help for the caretaker.

C. Through society's response to the problem of child maltreatment, there is hope for prevention.

Performance Objectives for Generalizations A and B

1. IDENTIFY the kinds of responses which help the maltreated child.
2. DESCRIBE the kinds of help available to the maltreated child.
3. IDENTIFY the kinds of responses which help the caretaker.
4. DESCRIBE the kinds of help available to the caretaker.

Instructional Objective Two for Generalization C

THE STUDENT WILL BE ABLE TO RECOMMEND RESPONSES WHICH PROVIDE HOPE FOR PREVENTION OF CHILD MALTREATMENT IN SOCIETY.

Performance Objectives for Generalization C

1. IDENTIFY those in society who must respond to the problem of child maltreatment.
2. DESCRIBE the kinds of responses which provide hope for prevention of child maltreatment in society.

UNIT VI. CHILD MALTREATMENT: HELP AND HOPE

Instructional Objective One

The student will be able to recommend responses to the problem of child maltreatment which provide help for both the child and the caretaker.

Performance Objectives for Generalization A

1. IDENTIFY the kinds of responses which help the maltreated child.
2. DESCRIBE the kinds of help available to the maltreated child.

Generalization A

THROUGH THE INDIVIDUAL'S RESPONSE TO THE PROBLEM OF CHILD MALTREATMENT THERE IS HELP FOR THE MALTREATED CHILD.

Sample Content

1. How to respond:
    - a) Recognize child maltreatment.
        - 1) Indicators of child maltreatment
        - 2) Problems inhibiting personal involvement
    - b) Report child maltreatment.
2. Kinds of responses:
    - a) Treatment or hospitalization
    - b) Individual and/or family therapy
    - c) Supervision at home
    - d) Court protection
    - e) Provision for alternative care

UNIT VI. CHILD MALTREATMENT: HELP AND HOPE

Instructional Objective One

The student will be able to recommend responses to the problem of child maltreatment which provide help for both the child and the caretaker.

Performance Objectives for Generalization B

3. IDENTIFY the kinds of responses which help the caretaker.
4. DESCRIBE the kinds of help available to the caretaker.

Generalization B

THROUGH THE INDIVIDUAL'S RESPONSE TO THE PROBLEM OF CHILD MALTREATMENT, THERE IS HELP FOR THE CARETAKER.

Sample Content

1. How to respond:
    - a) Recognize child maltreatment.
        - 1) Indicators of child maltreatment
        - 2) Problems inhibiting personal involvement
    - b) Report child maltreatment.
2. Kinds of responses:
    - a) Counseling by the helping professional
        - 1) Medical practitioner, psychiatrist
        - 2) Social worker, mental health assistant
        - 3) Pastor, trained lay person
    - b) Government Services
        - 1) Protective Service Agency
        - 2) Department of Welfare
        - 3) Department of Health
        - 4) The Judiciary
        - 5) Law enforcement agency

c) Community and Volunteer Agencies
    1) Parental Stress Service, Hot Lines
    2) Parents Anonymous, Families Anonymous
    3) Group therapy programs
    4) Residential programs

d) Education
    1) Increased knowledge of self and others
    2) Parenting skills
    3) Home management skills
    4) Financial management skills
    5) Job training skills
    6) Other

Suggested Classroom Activities and Procedures for Performance Objectives A and B 1 through 4

1. Prepare students for an understanding of Unit VI through utilization of:

    Unit I B

    Unit V D

2. Introduce Generalizations VI A and VI B, and write on board for students.

3. Refer students to Montgomery County Health Department Indicators of Child Maltreatment (VI.1) and Montgomery County Health Department Child Abuse/Neglect Information (VI.2) for discussion.

4. Develop VI A and B Sample Content 1 a), 2) Problems inhibiting personal involvement in the problem of child maltreatment, using examples such as:
    a) Indifference (It's not my problem.)
    b) Copout (I'll wait and see if it happens again.)
    c) Standoff (One instance isn't proof enough.)
    d) Disbelief (I really don't believe it.)

e) Dilemma (I just don't have enough facts.)

f) Traditional (It's the only way some kids will learn.)

5. Review selected case histories from Unit II, and slides depicting the maltreated child.
6. Review the local reporting process, utilizing for discussion:

   A Policy Statement on Child Abuse and Neglect; More About Project PROTECTION (VI.3)

   Protect a Child Help a Parent Our Community Responsibility (II.4)
7. Contact the local Child Protection Agency and report current local statistics along with current national statistics, as available (Transparency 1).
8. Review II A and B as necessary.
9. Develop VI A and B Sample Content 2 for both the maltreated child and the caretaker, utilizing for class discussion:

   Montgomery County Services for Maltreated Children and Their Families (VI.5)

   Even Parents Sometimes Lose Control (VI.6)

   The Extended Family Center (VI.9)

   Working With Abusive Parents, A Social Worker's View (VI.10)

   Working With Abusive Parents, A Psychiatrist's View (VI.11)

   Working With Abusive Parents, A Parent's View (VI.12)

   C.A.L.M.--A Timely Experiment in the Prevention of Child Abuse (VI.7)

   Child Neglect: Reaching the Parent (VI.8)
10. Invite a speaker from the local Child Protection Agency to discuss the role of the child protection team.
11. View the videotape "The Battered Child", an interview with Montgomery County Child Protection staff.
12. Conclude with assessment measures for Performance Objectives A and B 1 through 4.

Instructional Objective Two

The student will be able to recommend responses which provide hope for prevention of child maltreatment in society.

Performance Objectives for Generalization C

1. IDENTIFY those who must respond to the problem of child maltreatment.
2. DESCRIBE the kinds of response which provide hope for the prevention of child maltreatment in society.

Generalization C

THROUGH SOCIETY'S RESPONSE TO THE PROBLEM OF CHILD MALTREATMENT, THERE IS HOPE FOR PREVENTION.

Sample Content

1. Those who must respond:
    a) Enlightened parents
    b) Concerned citizens
    c) Alerted medical practitioners
    d) Informed social workers, teachers, and law enforcement authorities
    e) Dedicated legislators and social policy makers
2. Kinds of responses:
    a) Recognition and protection of the rights of children
    b) Improved environment for children
    c) Greater dissemination of knowledge about child maltreatment
    d) Adequate funding for child maltreatment prevention programs
    e) Increase in available community resources and services
    f) More compassionate understanding of the problem of child maltreatment

Suggested Classroom Activities and Procedures for Performance Objectives C 1 and 2

1. Prepare students for an understanding of Generalization VI C through in-depth review of Unit I The Phenomenon of Child Maltreatment and Generalization II C.
2. Introduce Generalization VI C, and write on board for students.
3. Have students read and discuss in class:

   Why Most Physicians Don't Get Involved in Child Abuse Cases and What to do About It (VI.14)

   Understanding and Helping Child-Abusing Parents (VI.15)

   Project PROTECTION, A School Program to Detect and Prevent Child Abuse and Neglect (VI.16)

   Child Abuse: Detection and Prevention (VI.17)

   Battered Children and Counselor Responsibility (VI.18)

   Preventing Child Abuse (VI.19)

   The Abused Parent of the Abused Child (VI.20)

   The Rights of Children (VI.21)

4. Students may:

   - Invite a member of the Montgomery County Task Force on Child Abuse, and write a paper on the subject of what steps are necessary or involved in establishing community action on child maltreatment
   - Interview a member of the Special Child Abuse Team, Children's Hospital, Washington, D.C.; and write a paper on what is involved in planning a program to help the maltreated child and the caretaker

- Interview the Montgomery County Child Protection Coordinator, and write a paper on the problems involved in coordinating community help for the maltreated child and the caretaker
- Interview a juvenile officer from the Montgomery County Police Department, and write a paper on citizen responsibility for the prevention of child maltreatment
- Interview at the state level one of the following, and write a paper on the subject of State legislative action on child maltreatment:
  - a) Montgomery County Delegate
  - b) Prince George's County Delegate
- Interview at the federal level one of the following, and write a paper on federal legislative action on child maltreatment:
  - a) An official of the Office of Child Development (HEW) on the subject of 1) child advocacy or 2) funding for child protection programs
  - b) A member of the Senate Subcommittee on Children and Youth on the subject of federal legislation to protect the rights of children
- Make art posters for school display to promote better understanding of child maltreatment
- Write an article for the school or local newspaper on some aspect of prevention of child maltreatment in society
- Sponsor a school assembly or PTA program to develop better understanding of child maltreatment

5. Conclude with assessment measures for Performance Objectives C 1 and 2.

EVALUATION

for

VI. Child Maltreatment: Help and Hope

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1 AND 2 -- UNIT VI. CHILD MALTREATMENT: HELP AND HOPE

Instructional Objective One: The student will be able to recommend responses to the problem of child maltreatment which provide help for both the child and the caretaker.

Generalization A Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 1. IDENTIFY the kinds of responses which help the maltreated child.		The student will give correct information by utilizing the resources listed below: VI A Sample Content 1
2. DESCRIBE the kinds of help available to the maltreated child.		VI A Sample Content 2

Key Word[1] (See Appendix A.)

IDENTIFY - to select from among several choices the item(s) that meet(s) certain criteria

DESCRIBE - to state a verbal picture or /to/ list the characteristics of a person, place, thing, or event

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[1] Thomas Evaul, Behavioral Objectives, Their Rationale and Development (Merchantville, New Jersey: Curriculum and Evaluation Consultants) 1972.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1 AND 2 --
UNIT VI. CHILD MALTREATMENT: HELP AND HOPE

Instructional Objective One: The student will be able to recommend responses to the problem of child maltreatment which providehhelp for the caretaker.

Generalization B Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 1. IDENTIFY the kinds of responses which help the caretaker.		The student will give correct information by utilizing the resources listed below: VI B Sample Content 1
2. DESCRIBE the kinds of help available to the caretaker.		VI B Sample Content 2

Key Word[2] (See Appendix A.)

IDENTIFY - to select from among several choices the item(s) that meet(s) certain criteria

DESCRIBE - to state a verbal picture or /to/ list the characteristics of a person, place, thing, or event

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2 Evaul.

SAMPLE ASSESSMENT MEASURES FOR PERFORMANCE OBJECTIVES 1 AND 2 --
UNIT VI. CHILD MALTREATMENT: HELP AND HOPE

Instructional Objective Two: The student will be able to recommend responses which provide hope for prevention of child maltreatment in society.

Generalization C Performance Objective	Sample Assessment Measure	Criteria for Satisfactory Attainment
The student will: 1. IDENTIFY those in society who must respond to the problem of child maltreatment.		The student will give correct information by utilizing the resources listed below: VI C Sample Content 1
2. DESCRIBE the kinds of responses which provide hope for the prevention of child maltreatment in society.		VI C Sample Content 2

Key Word[3] (See Appendix A.)

IDENTIFY - to select from among several choices the item(s) that meet(s) certain criteria
DESCRIBE - to state a verbal picture or /_to_/list the characteristics of a person, place, thing, or event

[3] Evaul.

CLASS RECORD FORM

S = SATISFACTORY

UNIT VI: CHILD MALTREATMENT: HELP AND HOPE

U = UNSATISFACTORY

CLASS ______________________________ PERIOD ______________

INSTRUCTIONAL OBJECTIVE ONE: The student will be able to recommend responses to the problem of child maltreatment which provide help for both the child and the caretaker.

INSTRUCTIONAL OBJECTIVE TWO: The student will be able to recommend responses which provide hope for prevention of child maltreatment in society.

	Inst. Obj. One Performance Obj.		Inst. Obj. Two Performance Obj.		Average %	
NAME	1	2	1	2	S	U
AVERAGE %	S				CLASS AVERAGE	
	U					

GRADE KEY

S----SATISFACTORY for PERFORMANCE OBJECTIVES

U----UNSATISFACTORY for PERFORMANCE OBJECTIVES

60% SATISFACTORY = CREDIT for COURSE

STUDENT ______________________

FINAL GRADE

TOTAL % SATISFACTORY for COURSE _____

TOTAL % UNSATISFACTORY for COURSE _____

INDIVIDUAL STUDENT RECORD

	PERFORMANCE OBJECTIVES																	AVERAGE % Instructional Objectives	
																		S	U
UNIT I Instructional Objective	1	2	3	4	5	6	7	8											
UNIT II Instructional Objective	1	2	3	4	5	6	7	8	9	10									
UNIT III Instructional Objective	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
UNIT IV Instructional Objective	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17		
UNIT V Instructional Objective One	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
UNIT V Instructional Objective Two	1	2	3	4	5														
UNIT VI Instructional Objective One	1	2	3	4															
UNIT VI Instructional Objective Two	1	2																	

CLASSROOM INSTRUCTIONAL MATERIALS

for

VI. Child Maltreatment: Help and Hope

1. Indicators of Child Maltreatment, Montgomery County Health Department (VI.1)
2. Child Abuse/Neglect Information, Montgomery County Health Department (VI.2)
3. "A Policy Statement on Child Abuse and Child Neglect"; "More About Project PROTECTION" (VI.3)
4. "Protect a Child Help a Parent, Our Community Responsibility" (VI.4)
5. Montgomery County Services for Maltreated Children and Their Families (VI.5)
6. "Even Parents Sometimes Lose Control" (VI.6)
7. "C.A.L.M.--A Timely Experiment in the Prevention of Child Abuse" (VI.7)
8. "Parental Stress Service--How It All Began" (VI.8)
9. "The Extended Family Center" (VI.9)
10. "Working With Abusive Parents, A Social Worker's View" (VI.10)
11. "Working With Abusive Parents, A Psychiatrist's View" (VI.11)
12. "Working With Abusive Parents, A Parent's View" (VI.12)
13. "Child Neglect: Reaching the Parent" (VI.13)
14. "Why Most Physicians Don't Want To Get Involved in Child Abuse Cases and What To Do About It" (VI.14)
15. "Understanding and Helping Child-Abusing Parents" (VI.15)
16. "Project PROTECTION: A School Program to Detect and Prevent Child Abuse and Neglect" (VI.16)

17. "Child Abuse: Detection and Prevention" (VI.17)

18. "Battered Children and Counselor Responsibility" (VI.18)

19. "Preventing Child Abuse" (VI.19)

20. "The Abused Parent of the Abused Child" (VI.20)

21. "The Rights of Children" (VI.21)

22. Instructional Materials for Units I, II, III, IV, and V

23. Classroom learning center for child maltreatment

Film

Don't Give Up On Me Produced for the Metropolitan Area Protective Service and the Illinois Department of Children and Family Services for use in case workers awareness training. This film uses real people in real situations to probe the reasons behind the child abuse pattern. A mother of two small children is in danger of having her daughter taken by the court, and the assigned social worker struggles to have the distraught mother come to grips with her problem.

Motorola Teleprograms, Inc. 1976 16mm color 28½ min.

Available from HELP Resource Project
1123 North Eutaw Street
Baltimore, Maryland 21201

CHILD MALTREATMENT: HELP AND HOPE (VI.1)

MONTGOMERY COUNTY
Health Department

INDICATORS OF CHILD MALTREATMENT

SUSPECT MALTREATMENT

When the child:

- has unexplained injury
- has injuries not mentioned in history
- has multiple injuries
- has injuries of different ages
- has history of repeated fractures
- has characteristic x-ray of long bones
- is neatly but inappropriately dressed
- is generally poorly cared for
- is unusually fearful or stoic
- shows evidence of sexual abuse
- takes over and cares for parent's needs
- has serious burns

When the parent:

- gives history inconsistent with injury
- gives contradictory history
- projects cause of injury on sibling
- delays bringing child for treatment
- shows evidence of losing control
- over-reacts or under-reacts to the situation
- persistently complains about irrelevant problems
- is uncooperative
- "hospital shops"
- cannot be located
- is psychotic or psychopathic

Children who may be at risk at birth:

- premature baby
- unwanted or unplanned baby (not equivalent of illegitimate)
- baby of addicted parent(s)
- baby in family with previous history of abuse
- twins or triplets.
- baby with major anomaly
- bonding failure (mother on maternity ward seems unrelated to neonate)

OFFICE OF HUMAN RESOURCES
Project PROTECTION
November 1975

MONTGOMERY COUNTY, MARYLAND
Health Department

Child Abuse/Neglect Information

COMPARISON OF ABUSIVE AND NON-ABUSIVE PARENT-CHILD INTERACTIONS

Abusive	Non-Abusive
Emergency Room	**Emergency Room**
1. Paradoxical dress--child appears in clean clothes inappropriate to illness or injury	1. Child appears in clothes worn at time of accident or illness
2. Parent shows over--or under-concern (cover-up for guilt feelings). May be hesitant to talk about injury; contradictions in story about events surrounding injury; improbable explanations as to cause of injury. May refuse permission for further diagnostic tests--may change hospitals.	2. Parent reports details surrounding injury/illness with consistency, accuracy, and spontaneity. History seems appropriate to clinical findings. Shows concern about injury and treatment.
3. Infant's crying is interpreted as a demand; and parents' response is thus angry and rejecting.	3. Parent tolerates crying and gives comfort to child.
4. Pre-school child: Is fearful of unpredictable environment and thus remains either immobile, or passive; there may be catatonic-like posturing; wide-open, unblinking visual gaze; examination not difficult as child is so docile.	4. Pre-school child: Clings to parent; rejects strangers; avoids eye contact with strangers; seeks to return to parent if separated; may scream, cry, kick, bite during procedures.
On Ward:	**On Ward:**
1. Parent raises no fuss about child being separated; lack of trust may keep him/her from expressing needs.	1. Parent wishes to remain with child, asks questions, exhibits appropriate affect and concern; visits frequently, brings toys and gifts; asks questions about discharge.

2.	Parent rarely involves himself in child's care; seems physically and psychologically separate from child; shows inability to cope with child's normal bodily functions.	2.	Parent becomes involved with care, touches child, not upset with normal body functions (e.g., vomitus or urination).
3.	Parent constantly critical of child, demands too much, expects behavior not appropriate to age and development level. Child made to feel guilty; is scolded or has punishment threatened for normally childish behavior.	3.	Parent is able to interpret child's needs and provide comfort and reassurance. (e.g., honesty in explanations, calming voice tones, assistance by holding child).

OFFICE OF HUMAN RESOURCES
Project PROTECTION
November 1975

Revised, August 26, 1974

Montgomery County Public Schools

a policy statement on Child Abuse and Child Neglect

POLICY

The Montgomery County Board of Education, recognizing the serious local, state, and national problems of child abuse and child neglect, affirms its position that the Montgomery County Public Schools shall cooperate vigorously to expose these problems by early identification of abuse or neglect and by reporting suspected cases to duly constituted authorities whether or not substantial corroborative evidence is available. School employees are in a unique position to discover potential cases of abuse and/or neglect of children and youth through the age of seventeen years. Employees are required by Maryland law to report suspected cases of child abuse to the Department of Social Services or Juvenile Section of the Montgomery County Police Department. Suspected child neglect is to be reported to the Department of Social Services.

Effective action by school employees can be achieved through recognition and understanding of the problem, knowing the reporting procedures, and participating in the information programs in child abuse provided for Montgomery County Public Schools employees. Guidelines have been developed to provide direction for staff members in reporting suspected child abuse or child neglect cases. Staff personnel should be aware that by statute they are immune from any civil and/or criminal liability when reporting suspected child abuse, and from any civil liability when reporting suspected child neglect. Failure to report, on the other hand, might result in legal action being brought against a staff member and disciplinary action by the school system. Any doubt about reporting a suspected situation should be resolved in favor of the child, and this situation should be reported immediately.

Any Montgomery County Public Schools employee who has reason to believe that a child has been abused or neglected, shall report this information in the form and manner provided.

To maintain awareness on the part of all professional staff members, the Montgomery County Public Schools will provide periodic staff development on the subject of child abuse and neglect.

INFORMATION ON AND PROCEDURES FOR REPORTING SUSPECTED ABUSED AND NEGLECTED CHILDREN

I. REPORTING CASES OF CHILD ABUSE

An abused child is any child under the age of eighteen who a) has sustained physical injury as a result of cruel or inhumane treatment or as a result of malicious acts by his parent or any other person responsible for his care or supervision; b) has been sexually molested or exploited, whether or not he has sustained physical injury, by his parent or any other person responsible for his care or supervision.

The abuse of children can cause permanent physical damage, and may be fatal. Researchers have found a very significant number of abusing parents were themselves abused as children. Perpetrators of violent crimes against persons – even teenage offenders – have frequently been found to have a past history of abuse by their parents or guardians.

Once considered a syndrome that affected only children under three, child abuse today is found as frequently among school-age children. Half of the known cases at the present time are school-age children, with the number who are adolescents rapidly increasing. Educators are in a unique position to identify and report child abuse. Every effort must be made to identify abused children and to prevent repeated abuse.

All Montgomery County Public Schools employees are required by law to report *suspected* cases of child abuse. As soon as an employee has reason to believe that a child may have been abused, he must call the Protective Services Section of the Montgomery County Department of Social Services, 279-1758, or the Juvenile Section of the Montgomery County Police Department, 762-1000. Simultaneously, the reporting person shall notify the principal that a report has been made. The obligation of the principal to report cases of suspected child abuse brought to his attention by his staff is not discretionary, and he shall assure that the case is duly reported if the reporting person has not done so.

When a report of suspected abuse has been made, a police officer accompanied by a social services worker will respond at once.

Within forty-eight hours, the person making the original oral report must send a written report of the incident to the Department of Social Services, with copies to the Montgomery County State's Attorney, the Juvenile Section of the Montgomery County Police Department, and the Supervisor of Pupil Personnel at the central office. One copy of the report will be kept in a confidential file by the principal but not placed in the pupil's folder. Montgomery County Form 335-44 is to be used for this written report.

A. Immunity

Anyone who reports suspected child abuse in good faith, or who participates in any investigation or judicial proceeding which results from a report of suspected child abuse is immune from civil liability or criminal penalty. Failure to report could result in a lawsuit with the possibility of substantial damages should an injured or murdered child's guardian be able to establish that the school employee had prior knowledge or suspicions which, if reported, might have prevented further injury to the child.

B. Reporting Cases Not Involving Apparent or Obvious Physical Injury

It is not necessary that the reporting employee observe any external physical signs of injury to the child. It is sufficient merely to presume that abuse has occurred when a child complains of having been sexually molested or of pain, which he says has resulted from an inflicted injury. In such cases the report should be made.

Employees should be aware that abused children typically explain injuries by attributing them to accidents in play or to sibling conflict. In any case, no employee should attempt to press a child on the subject of parental or guardian abuse to validate the suspicion of child abuse. Validation of suspected abuse is the responsibility of the Department of Social Services, assisted by the police. *Any doubt about reporting a suspected situation is to be resolved in favor of the child* and the report made immediately.

Purpose of Intervention

eports of suspected child abuse are carefully investigated ly by the Police Department's Juvenile Section ctives and social workers from the Department of Social ices. Each case receives a professional evaluation leading to ever civil action may be necessary to ensure treatment for amily. Treatment may include a full range of therapeutic rams. The abuser is not subject to indiscriminate criminal ecution. The State's Attorney and the police work closely all involved professional personnel and authorities to lish alternatives to prosecution, whenever possible.

REPORTING CASES OF CHILD NEGLECT

he Montgomery County Department of Social Services has legal responsibility for evaluating reports of suspected l neglect and for taking legal action to protect a child re necessary. Under Article 77, Section 116A of the otated Code of Maryland, any educator who acts upon nable grounds in the making of any report required by rule, or regulation or who participates in judicial eedings which result from such report shall be immune any civil liability which occurs. A neglected child may be of the following:

. Malnourished; ill-clad; dirty; without proper shelter or ing arrangements; lacking appropriate health care

. Unattended; without adequate supervision

. Ill and lacking essential medical care

. Denied normal experiences that produce feelings of g loved, wanted, secure (Emotional neglect)

. Unlawfully kept from attending school

. Exploited; overworked

. Emotionally disturbed due to continuous friction in the e, marital discord, mentally ill parents

. Exposed to unwholesome and demoralizing mstances

ll suspected child neglect cases should be reported on tgomery County Form 335-44 to the Department of al Services and the Supervisor of Pupil Personnel. *If there y doubt or question in reporting such cases, it should be ved in favor of the child.*

CONTENT OF REPORTS

ral and written reports shall contain the following mation, or as much data as the person making the report rovide:

. The name(s) and home address(es) of the child(ren) and parent or other person responsible for the care of the l(ren)

. The present whereabouts of the child(ren) if not at e

The age(s) of the child(ren)

The nature and extent of the abuse or neglect suffered e child(ren), including any evidence or information that be available to the person making the report concerning previous physical or sexual abuse or neglect.

MONTGOMERY COUNTY GOVERNMENT **Rockville, Maryland**	**REPORT OF SUSPECTED CHILD ABUSE / CHILD NEGLECT**

Instructions: Respond to each item even if reply is "unknown" or "none." For suspected child abuse, this report must be filed within 48 hours after oral report. Retain original, send copies as indicated below to Department of Social Services, your agency's administrative office, State's Attorney's Office and Police Juvenile Section. For suspected child neglect, retain original; send copies to Department of Social Services, and your agency's administrative office. Destroy others. Type or print firmly on hard surface. (See reverse side for definitions and additional instructions.)

Check type of referral: ☐ SUSPECTED CHILD ABUSE ☐ SUSPECTED CHILD NEGLECT

TO: MONTGOMERY COUNTY DEPARTMENT OF SOCIAL SERVICES

FROM:

Name ______ Agency/school ______

Address ______ Phone ______

NAME OF CHILD

ADDRESS (WHERE CHILD MAY BE SEEN)

AGE OR BIRTHDATE

NAME OF PERSON(S) RESPONSIBLE FOR CHILD'S CARE (Parents/Guardian)

Father ______ (first, middle, last name) Phone ______

Mother ______ (first, middle, last name) Phone ______

Guardian ______ (first, middle, last name) Phone ______

Address ______

Relationship of guardian, if any ______

The nature and extent of the current injury to the child, circumstances leading to the suspicion that the child is a victim of abuse/neglect:

Information concerning previous injury or conditions of neglect to this child or other children in this family situation, Including previous action taken, if any:

Any other information available to you which would be of aid in establishing the cause of the injuries and/or neglect.

SIGNATURE OF PERSON MAKING REPORT	DATE & HOUR OF ORAL REPORT	TO WHOM REPORTED Name Agency	DATE COPIES MAILED

DISTRIBUTION			For Suspected Abuse Only	
WHITE/Montgomery County Dept. of Social Services 5830 Fishers Lane Rockville, Md. 20852 (279-1758)	GREEN/Your agency's Administrative Office (For Mont. Co. Public Schools central office, Supervisor of Pupil Personnel	YELLOW/Retain	PINK/State's Attorney for Montgomery County P.O. Box 151 Rockville, Md. 20850	GOLD/Montgomery County Police Juvenile Section 2300 Randolph Rd. Wheaton, Md. 20902 (762-1000)

MCPS Form 335-44, Revised August 1974

DEFINITIONS OF CHILD ABUSE AND CHILD NEGLECT

CHILD ABUSE

Any physical injury or injuries sustained by a child under the age of eighteen (18) as a result of cruel or inhumane treatment or as a result of malicious act or acts by any parent or other person who has the permanent or temporary care or custody or responsibility for supervision of the child.

Whether physical injuries are sustained or not, any sexual abuse of a child under the age of eighteen (18) by any parent or other person who has the permanent or temporary care or custody or responsibility for supervision of the child.

"Sexual abuse" is defined by Maryland law as "any act or acts involving sexual molestation or exploitation, including but not limited to incest, rape, carnal knowledge, sodomy, or unnatural or perverted sexual practices."

ADDITIONAL INSTRUCTIONS FOR REPORTING CHILD ABUSE

1. A report must be submitted on any case in which child abuse is suspected. It is not necessary to observe outward signs of injury to the child. Neither is it necessary for the reporter to establish proof that abuse has occurred. Protection of the child is paramount. If abuse is suspected, a report must be submitted.

2. Every health practitioner, educator or social worker or law-enforcement officer, who contacts, examines, attends, or treats a child and who believes or has reason to believe that the child has been abused is required to make a report to either,
Social Services, 279-1758 or Police, 24 hours, 762-1000

3. Each such report shall be made both orally and in written form; both the reports to be made as soon as is reasonably possible in the circumstances, but, in any case, the written report must be made within forty-eight (48) hours of the contact, examination, attention or treatment which disclosed the existence of possible abuse.

4. Any person including a health practitioner, educator, or social worker or law-enforcement officer, participating in the making of a good faith report, or participating in an investigation or in a judicial proceeding resulting therefrom shall in so doing be *immune from any civil liability or criminal penalty that might otherwise be incurred or imposed as a result.*

CHILD NEGLECT

There is no requirement in law to report suspected neglect, but such report is highly encouraged.

There is no immunity from civil suits for untrue statements made by one citizen against another.

A Neglected Child May Be Any One of the Following:

1. Malnourished; ill-clad; dirty; without proper shelter or sleeping arrangements; lacking appropriate health care.
2. Unattended; without adequate supervision.
3. Ill and lacking essential medical care.
4. Denied normal experiences that produce feelings of being loved, wanted, secure. (Emotional neglect)
5. Unlawfully kept from attending school.
6. Exploited, overworked.
7. Emotionally disturbed due to continuous friction in the home, marital discord, mentally ill parents.
8. Exposed to unwholesome and demoralizing circumstances.

Timely information about what one school system is doing about child abuse and neglect.

Diane D. Broadhurst is the Coordinator and Maxwell C. Howard is Curriculum Specialist of Project PROTECTION, Montgomery County Public Schools, Rockville, Maryland.

More About PROJECT PROTECTION

Diane D. Broadhurst and Maxwell C. Howard

IN 1972 the brutal death of a nine-year-old child and the indictment for murder of her father and stepmother shocked the citizens of Montgomery County, Maryland. This case soon became the catalyst for an intensive community effort to alert residents to the phenomenon of child abuse and neglect and to improve methods of reporting and handling such incidents.

Since then Montgomery County, one of the largest school districts in the nation, has made significant progress in developing a school-based program to detect and prevent child abuse and neglect. Its program—Project PROTECTION—can now serve as a model for other school systems as they try to help the tens of thousands of school-age children who are abused or neglected every year.

From the beginning, the public schools were part of this community effort. A Task Force on Child Abuse was charged by the County Executive with developing programs to improve services to abused and neglected children and their families. Included were members from the school system, community health and social services, law enforcement agencies and the lay public. Under a comprehensive plan developed by the Task Force, the position of Child Protection Coordinator was established and health and social services staffs were increased to receive and investigate reports. A multidisciplinary Child Protection Team, which included school staff, was formed to evaluate cases and to develop service plans for handling cases. Health, police and social services policies were reexamined and modified, and the Montgomery County Board of Education adopted a Policy Statement on Child Abuse and Neglect.

THE SCHOOL-BASED PROGRAM: FOUR PHASES

Already a leader among school systems in the nation with regard to child-protection activities, Montgomery County intensified its efforts in August 1974 by initiating a school-based program, Project PROTECTION: A Multidisciplinary Approach to Educational Problems Associated with Child Abuse and Neglect. This project is one of three funded by the U.S. Office of Education under Title III of the Elementary and Secondary Education Act to train educators in the recognition and referral of suspected victims of child abuse and neglect.

Project PROTECTION efforts thus far have involved four phases: policy revision, staff development, direct service to county nonpublic schools, and curriculum development. In the policy revision phase, the system's 1973 Policy Statement on Child Abuse and Child Neglect was revised to conform to 1974 amendments to the Maryland Child Abuse statute. One of the few such school policies in the nation, it requires that all school staff refer to proper authorities any suspected victim of child abuse or neglect and emphasizes that any doubt about reporting a suspected situation should be resolved in favor of the child.

The policy, which includes reporting procedures with a sample reporting form, explains that immunity from any civil or criminal liability is granted under state law. Copies of the policy statement were sent to every school staff member and circulated throughout the community. Additional copies were sent to many other school systems throughout the state and nation.

Staff development, the largest part of Project PROTECTION, was carried out as a three-phase operation, beginning in September 1974 with a one-day conference for all public school administrative and supervisory personnel. This conference was followed by an intensive two-day seminar for school pupil services administrative staff. Finally, the pupil services administrative staff conducted local staff development programs during regularly scheduled faculty meetings in each of the county's 201 public schools. The local school presentations reached a total of 6,900 staff members and helped them recognize indicators of child abuse and neglect. Besides being informed of their legal responsibility to report and the immunity granted by law, they were briefed on the proper referral procedures. Similar programs were also offered to staff members in county nonpublic schools. A number of high school and college classes, as well as PTAs and service groups, also requested informational programs on child abuse and neglect.

The direct service phase of Project PROTECTION was designed to reach the 15 percent of the school-age children in Montgomery County who attend nonpublic schools. Information on child abuse and neglect was distributed to each nonpublic school, and staff development activities were held in many of them, including programs for parent and student groups. In a program focusing on early detection and prevention of abuse and neglect, a field unit from the National Catholic School of Social Services provided direct social work services in nine of these schools.

GETTING DOWN TO CASES

Throughout the county schools, there has been a steady rise in the number of cases reported as more and more staff began to recognize victims in their classrooms and took steps to help them.

Jennie—"Mother Got Mad"

Typical of the cases reported was Jennie K., a kindergartner who was referred to the county Protective Services unit by her teacher when she came to school one afternoon with a split lip and badly bruised mouth. Gently questioned by the teacher, Jennie said, "Mommy got mad and hit me."

Jennie's teacher had been concerned about her for some time. Withdrawn and isolated, Jennie remained apart from her classmates. Although Jennie said she liked school, she was frequently absent and took little part in classroom activities. Yet she was always the last to leave the room and sometimes cried when it was time to go home.

Investigation confirmed that Jennie had been abused. Her back was covered with new and healing scars, marks of previous injuries. X-rays revealed several old rib fractures; there were circular burn marks as well. Mrs. K. explained that she had never liked Jennie, who was "just like" Mr. K., from whom she was divorced. She added that she did not want children and had "gotten rid of" her other pregnancies.

After a court hearing determined that the continued risk to Jennie was substantial, the girl was placed in foster care. She is now living with relatives in another city. Her placement is considered permanent.

Eric—The Tolls of Alcoholism

Often there is a tendency to view child neglect as less important than child abuse, but serious neglect can have devastating effects on a child, as the following case illustrates.

Eric T., a slightly built first-grader, was absent from school more often than not. When he came to school, he was often oddly dressed and hungry. In class he was passive and withdrawn. He had great difficulty separating fantasy from reality and appeared to be retarded.

The school, concerned about his functioning in class, tried to arrange a meeting with Eric's parents. Appointment after appointment was scheduled and broken. Home visits were unsuccessful; the T.'s were not at home. In growing concern, the school referred Eric to Protective Services as a neglected child.

This case was staffed by the Child Protection Team, which requested a Health Department evaluation for Eric. The evaluation concluded that Eric was of normal intelligence though seriously disturbed. Physically he was small for his age and undernourished. There was no evidence of physical abuse.

The Protective Service investigation revealed that both Mr. and Mrs. T. were alcoholics. Unable to hold a job for any length of time, they lived a hand-to-mouth existence. Largely ignored, Eric was left alone to survive as best he might.

Eric is now in foster care where he is receiving psychiatric counseling. The school provides special tutoring, and Eric is beginning to catch up academically. Mrs. T. has agreed to accept alcoholism counseling. Mr. T. refuses all offers of help. The prognosis for the family is uncertain.

Tom—Buckle Discipline

Only rarely is it necessary to remove a child from his home. Jennie and Eric are extreme examples. A more typical case is that of Tom B., an upper elementary grade boy.

One morning Tom complained to his teacher of having been beaten by his father the night before. The teacher's first instinct was to discount the story. Tom was known for bizarre and untrue tales. However, she took the boy to the nurse's office where it was discovered that Tom's back and buttocks were crisscrossed with black-and-blue marks. The imprint of a belt buckle was clearly visible. Protective Services was called at once.

When the Protective Service worker visited the home, a remorseful Mr. B. admitted the beating. He said he and his wife could no longer handle Tom. When the boy came in late the night before, his parents were determined to "teach him a lesson." Mr. B. explained how he took off his belt and began to hit Tom. It was, he said, the way his father had disciplined him when he "got out of hand." When Tom refused to cry, Mr. B. became enraged and began to use the buckle.

Mr. and Mrs. B. agreed that there were other, better methods of discipline, and they were willing to join a family therapy group. Parents and child continue to be seen weekly; there have been no further incidents of abuse.

EMPHASIZING PREVENTION

The curriculum development phase of Project **PROTECTION** addresses the prevention aspects of child abuse and neglect. If we are ever to reduce the number of abused and neglected children, we must look to prevention, and that begins with today's students, the parents of tomorrow. The project is preparing a course of study on the child maltreatment syndrome, designed for use at the secondary level. The course will focus upon understanding nurturing in infancy and early childhood in relation to the ability to achieve emotional maturity in later life. It will also be concerned with understanding how the use of violence in the home results in a cycle of violence in both the individual and in society. Finally, the course will promote understanding of stress, its manifestations in society and in the individual, and how the individual copes with stress. Selected modules of the course are being piloted during the current school year.

Even in its first year of operation, Project **PROTECTION** has demonstrated that a school-based program can have a significant impact in the early detection of child abuse and neglect. In Montgomery County, school reports of suspected child abuse have more than doubled, from 63 in the 1973-74 school year to 140 in 1974-75; the total of confirmed cases of physical abuse has quadrupled. In 1971, before Montgomery County began its awareness program, only 12 cases of suspected child abuse were reported throughout the county.

Although Project **PROTECTION** is a federally funded school program, the project staff has worked closely with county agencies and institutions. This past June, in cooperation with the Montgomery County Office of Human Resources, the Departments of Health and Social Services, and the Mental Health Association, Project **PROTECTION** sponsored a workshop on Emotionally Neglected Children. Other similar workshops are planned in the future.

Project **PROTECTION** has thus become an integral part of Montgomery County's overall plan to combat child abuse and neglect.

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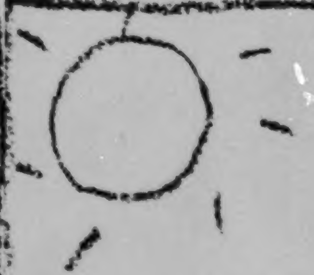
3615 Wisconsin Avenue, N.W., Washington, D.C. 20016

protect a child

help a parent

Our community responsibility



will you help ...

Cruelty to children is not new, but it still shocks us: we find it hard to believe that children may be harmed by their own parents. Yet child abuse can occur in any family, regardless of income, faith, or color.

When a parent becomes overwhelmed by stresses such as unemployment, poor housing, alcoholism, or isolation, a child may be abused or neglected. Often parents who abuse their children were themselves mistreated as children; yet most parents, including those who abuse and neglect their children, want to be good parents.

You could be the first link between a vulnerable child and needed help.

how can you help ...

To help break the cycle of neglect and abuse, children and parents involved must first be identified. Since parents and children are often reluctant to ask for help, you can help by reporting cases of suspected abuse and neglect.

Maryland law requires every person to report suspected child abuse and extends immunity from civil liability or criminal penalty to all who report in good faith.

Child abuse includes: any physical injury to a child under 18 by a parent or caretaker, as a result of cruel or inhumane treatment; any sexual abuse to a child under 18 by a parent or caretaker whether physical injuries are sustained or not.

While there is no requirement to report neglect, reporting is highly encouraged. Neglect can be harmful to a child and and may even be the forerunner of abuse. Neglect includes such things as: emotional deprivation, malnourishment, lack of essential medical care, unlawfully being kept from attending school.

what to look for ...

A child who is physically abused may have bruises, welts, or burns which do not fit with the explanation of how the injury occurred. Or the child may complain of having been beaten or sexually abused.

A neglected child may appear tired, listless, hungry, or be left unsupervised at odd hours. The child may be forced to assume adult responsibilities at an inappropriate age.

how to report ...

If you have reason to believe that a child has been abused, or you are concerned that a child is being neglected, you should phone Protective Services at the County's 24-hour reporting line, 279-1758. Health practitioners, educators, social workers, and police officers are required by law to report both by telephone and in writing.

what happens after a report ...

All reports of abuse are promptly investigated by a Social Worker and the Juvenile Police. A Social Worker will investigate neglect as quickly as possible, depending upon the seriousness of the report.

The prime consideration is protection of the child. Usually, the best way to protect the child is to help make the home safe and secure. Therefore, Protective Services, after the investigation, offers assistance and treatment to the family.

Some families' problems are reviewed by the Child Protection Team, a multidisciplinary body which consults with Protective Services Social Workers. Often community agencies such as the Health Department and Public Schools are also involved in helping.

do you need help ...

If you get so angry with your kids you're afraid you'll hurt them . . .

If you want to be a better parent, but don't know where to turn for help . . .

call hotline 949-6603

24 hours a day, 7 days a week

Someone is always available to listen while you talk about your problems—to offer support, understanding, help.

TO REPORT SUSPECTED ABUSE/NEGLECT

DEPARTMENT OF SOCIAL SERVICES
Protective Services 279-1758
(24 hours a day)
(After some hours this phone
will be answered by police)
5630 Fishers Lane
Rockville, Md. 20852

FOR INFORMATION OR TRAINING SESSION

OFFICE OF HUMAN RESOURCES
Child Protection Coordinator
279-1512
301 E. Jefferson St.
Rockville, Md. 20850
Or
DEPARTMENT OF SOCIAL SERVICES
279-1751
5630 Fishers Lane
Rockville, Md. 20852

TO "RAP" ABOUT YOUR PROBLEMS
HOTLINE 949-6603

MONTGOMERY COUNTY
GOVERNMENT
Office of Human Resources
279-1512
5/75

MONTGOMERY COUNTY SERVICES FOR MALTREATED CHILDREN AND THEIR FAMILIES

Many community resources are available to the individual in Montgomery County. A Directory of Community Resources may be found in libraries throughout the county. For information or help in locating appropriate resources, telephone 279-1900. The following is a general description of services by agency.

DEPARTMENT OF SOCIAL SERVICES

The Protective Service Unit of the Montgomery County Department of Social Services investigates and evaluates all reports of suspected child abuse and neglect to determine the validity of the allegation. Twenty-four hour response to reports of abuse and serious neglect is provided. Continuing services are provided on behalf of abused and/or neglected children who remain in their own homes, in the home of relatives, or in short-term placements through casework and group-work services.

The Maryland Child Abuse Law mandates that reports of suspected abuse be made either to the local department of social services or to the appropriate law-enforcement agency. The agency to which the report is made shall immediately contact the other.

Unique to Montgomery County is the manner in which abuse reports are investigated. In all such reports, the investigation is conducted by a social worker and a Juvenile Aid officer of the police department and is begun within an hour of the oral report. To better implement the immediacy of investigations and to provide evening coverage, a "night shift" worker is maintained physically at the police station from 6:00 P.M. until midnight. The provision for a night duty worker has been in effect since September 1973 and has greatly contributed to a better working relationship between police and social services. The procedure of involving two agencies in the investigation has greatly expedited the immediate investigation of all reports of suspected child abuse.

Reports of suspected neglect are investigated by the Protective Service staff within ten days of the receipt of the report. As with abuse situations, continuing services are provided to the family if neglect is confirmed, or a referral may be made to the Agency appropriate to provide those services needed by the family.

Montgomery County has a number of resources available for families receiving services for neglect and abuse. Within Social Services, the following programs are available to families who meet eligibility requirements:

1. Public Assistance (Aid to Families with Dependent Children, General Public Assistance, and General Public Assistance for Employables)

2. Food Stamps

3. Medical Assistance

4. Emergency Shelter Care Placement -- a local policy and an additional bed subsidy maintain homes to receive children requiring immediate placement 24 hours per day

5. Foster Care -- including the purchase of specialized foster home care, group home care, or institutional care from other agencies.

6. Single Parents Service -- a specialized counseling and planning service for those with unplanned pregnancies

7. Adoption -- including subsidized adoption and permanent foster care

8. Homemaker Service

9. Day Care -- both in family homes and in centers. Montgomery County has 15 non-profit full day centers. Subsidized day care is available in non-profit or proprietary centers.

HEALTH DEPARTMENT

The Health Department provides a special examination procedure for children suspected of being maltreated. This procedure provides that except in cases of serious or life-threatening injuries, any suspected victim of child abuse needing medical examination or treatment, and any child deemed in danger of physical abuse and removed from his home by Protective Service, will be examined by Health Department staff at either the Montgomery Georgetown Comprehensive Clinic in Takoma Park or at the Bethesda Clinic. Whenever a child has sustained serious or life-threatening injuries (or when a case is reported after clinic hours), the child is taken at once to the nearest hospital Emergency Room.

In addition to this special service, the County Health Department has six area centers providing the following:

1. School Health Services -- including nursing service in schools, medical consultation, and vision and hearing screening

2. Preventive health services -- child and adolescent health clinics for medical evaluation, multi-phasic screening, and parent education in child health and development.

3. Health Department Comprehensive Care Clinics (Areas I and IV)

4. Maryland Medical Assistance Program -- sick care provided through the private physician

5. Maternity and Family Planning Services

6. Mental Health Services including purchasing treatment from the Community Psychiatric Clinic. (These services use a sliding scale fee based upon income.)

Among relevant county-wide health services provided centrally are the following:

1. Specialty,consultation services such as those for seizure and cardiac, orthopedic, and multihandicapping problems

2. Passage Crisis Center

3. Juvenile Court Evaluation Team

4. Drug Alternatives Program

5. Day Care Licensing and Consultation Services (health component)

OFFICE OF HUMAN RESOURCES CHILD PROTECTION SERVICES

1. Child Protection Coordinator

The Child Protection Coordinator performs broad functions to ensure unduplicated, adequate services for child protection of and for treatment of abusing/neglectful families; to ensure continuing education for the lay public, educators, health and mental health professionals, the legal community, and para-professionals; to identify gaps and propose measures to fill them; and to suggest and support research and funding for projects involving child abuse and neglect. These educational efforts are aimed both at attempting to prevent abuse and neglect and at increasing the community's ability to recognize and report existing cases.

2. Child Protection Team

The Child Protection Team is a multi-disciplinary group which serves in an advisory and consultative capacity to the Protective Service Unit of the Department of Social Services. The team comprises a Protective Services supervisor; a pediatrician and a public health nurse from the Health Department; a juvenile officer from the Police Department; a pupil personnel supervisor from Montgomery County Public Schools; a lawyer from the County Attorney's office; and a psychiatrist in private practice. The team meets weekly to staff cases of child abuse and neglect and to make recommendations for case handling.

MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS)

MCPS provides case-finding and family services through its pupil personnel services. A broad range of educational diagnostic services, psychological services, and special placements are available.

OTHER COMMUNITY SERVICES

Within the community, Montgomery County has the following services:

1. Public Housing through the Montgomery County Housing Authority
2. Family Services of Montgomery -- a private United Way counseling agency
3. The Community Psychiatric Clinic -- a large private treatment clinic
4. Jewish Social Services -- a multi-functional private social agency partially supported by United Way
5. Catholic Charities -- a multi-functional private social agency
6. Mental Health Association -- an agency offering a number of mental health services including Hotline, a 24-hour-a-day telephone service, operating seven days a week, providing an immediate listening ear and/or referral information for all residents of Montgomery County
7. A number of church-sponsored HELP and FISH groups -- providing emergency food and clothing and information day or night

EVEN PARENTS SOMETIMES LOSE CONTROL

Do you get so angry with your kids you're afraid you'll hurt them?

Do you want to be a better parent but don't know where to turn for help?

We can offer you...

someone to listen while you talk about your problems...

support...understanding...help.

Call HOTLINE - 949-6603
24 hours a day 7 days a week

Administered by
The Mental Health Association of Montgomery County, Md.
Funded by
Montgomery County Government, Office of Human Resources

Since 1970, Enid Pike has been Executive Director of C.A.L.M., a pioneer program to prevent child abuse and neglect in Santa Barbara. A graduate of the University of California at Santa Barbara, Mrs. Pike, a grandmother, is currently working toward a Social Services Certificate. She was Co-Founder and Director of a school for Japanese brides of United States servicemen in Tokyo.

C.A.L.M. — A TIMELY EXPERIMENT IN THE PREVENTION OF CHILD ABUSE

By ENID L. PIKE

It has always been the prerogative of parents to handle the disciplining of their children in whatever way they choose and to administer punishment in whatever degrees of intensity they determine. Not until very recently has any widespread concern been shown for abusive action against children. However, an intense awareness of the syndrome is spreading readily among legal, medical and social workers, students in colleges and high schools, and among enlightened citizens everywhere. As a direct result of one woman's work and concern with the problem, a new exciting, experimental project has developed in Santa Barbara, California. Child Abuse Listening Mediation, or "C.A.L.M." as it is better known, is a unique pioneering venture in *prevention* of child abuse and neglect.

Three years ago a Santa Barbara physician's wife, Mrs. Harold Miles, attended the indictment of a nineteen year old college student who was accused of beating his child to death. He was dry-eyed throughout the proceedings. Stony faced, he heard the charges against him. Before he was led out of the courtroom, an older man, a social worker, with compassion showing in his face, placed his hand on the boy's shoulder and said gently, "Son, why don't you tell me what really happened?" The boy disintegrated in tears. This man's expressions of kindness and concern were the first indications anyone had shown of caring what the boy's problems might be or what had caused him to commit such a crime. Mrs. Miles was deeply disturbed by the implications of this incident.

Soon after, a "Letter to the Editor" of the Santa Barbara *News Press* (11/21/67), written by a social worker at the Mental Health Department, further stimulated Mrs. Miles' concern. The worker was outraged by the indifferent response from the public to a situation involving a four-year-old battered little girl. Patrick LaCommare wrote, "Why is it that before the public is aroused and action taken a child has to be beaten and perhaps killed?" He appealed to all agencies and individuals who shared his concern to meet together "in conference as a first and urgent step toward closing the gaps in community services for children that exist throughout Santa Barbara County." His only reply came from Mrs. Miles.

Their subsequent meetings and discussions launched her into an intensive investigation of the problem of child abuse and child neglect throughout the United States. She wrote to major cities noted for their children's protective services. She contacted C. Henry Kempe, M.D., Chairman of the Department of Pediatrics at the University of Colorado. She flew to Fort Lauderdale, Florida, to talk with Judge Frank A. Orlando, who has worked for many years toward influencing legislation to aid mistreated children. Mrs. Miles wrote to the Society for the Prevention of Cruelty to Children in New York City. Other cities were contacted and information gathered. The composite results of her research pointed out that relatively few areas have become involved in any depth with constructive programs to combat child abuse and neglect. She found no organization committed entirely to prevention.

The statistics Mrs. Miles gathered regarding other communities pointed out their need for services to combat the problem where it had been established that child abuse existed. But who would believe that such a problem exists in the small, retirement, vacation center of Santa Barbara? Mrs. Miles needed evidence. She devised a daring, imaginative plan and solicited help from a Santa Barbara *News-Press* reporter, Jenny Perry, who covered her experiment in three consecutive Sunday news items. Mrs. Miles had a private, unlisted telephone installed in her home for thirty days. Headlines of the first article on March 15, 1970, read: KNOW OF MISTREATED CHILD? TELL SOMEONE THE SITUATION. Beneath a large picture of a telephone was the caption: "Information about maltreatment of children is being collected this month by Mrs. X, who plans to sit by the phone through April 14 answering all who call 964-4415. Information about the community problem, not punishment, is the point, she says." During the thirty days, twenty-eight cases of child abuse or neglect were reported anonymously.

Supported by this proof that Santa Barbara shares the problem of child abuse with other communities everywhere, Mrs. Miles brought together a steering committee, and with the help of a young attorney, Robert Monk, a proposal for a five-month pilot project was drawn up. Under the sponsorship of the Women's Auxiliary to the Santa Barbara County Medical Society, the proposal was presented to the County Board of Supervisors. It was approved and funding provided for the experimental project. So as a result of Mrs. Miles' long study, hard work, public relations and faith, on October 1, 1970, Santa Barbara began to do something positive to combat its problem of mistreated children. Provisions were made in the budget for a paid Director to serve on a twenty-four hour, seven-day-a-week emergency call basis. Her duties would be to organize, implement and maintain the operation. No guidelines were available, since no other such organization was known to exist anywhere. Consequently, C.A.L.M. has developed completely along lines of public need and response to a new and vital public service. At the end of the first year, an accumulated two hundred thirteen cases required the additional help of an Assistant Director, Mrs. Bruce Keiper, and during the second year, Mrs. Marguerite Faherty joined the staff as Secretary.

C.A.L.M.'s initial pilot project was started primarily to determine the feasibility of an outreach appeal to parents with problems, who according to known criteria, are demonstrating symptoms of potential child abuse. The program is designed to solicit their voluntary response and involvement in seeking and accepting help. Such self referral is seen as the keystone of a preventive approach in this field and is widely acknowledged by leading experts in the field. The fact that most efforts aimed at protection of children stem from some form of governmental agency tends to mitigate against self-referral and to place intervention after the fact. Nowhere else in the United States, prior to the beginning of C.A.L.M., was there any organization devoted entirely to prevention.

C.A.L.M.'s program began October 1, 1970, and early on that first morning a call came in from a distressed mother, Ruth Lee. Her three children, all younger than five, were getting too much for her to handle alone. Her husband had divorced her right after the birth of their third child. For awhile, he had sent what money he could to help, but he could not hold a steady job. Later he moved away and communications from him ceased. Through a friend, Ruth learned that he was out of work and living a deplorable existence himself. No help would come from him. She was forced to apply for assistance from welfare, which served to meet only the bare essentials of their needs. Most of all, she explained, she felt trapped and unable to cope with the stresses of poverty and trying to meet the needs of her three active sons alone. She wept as she told her story. Her mother was dead – her father an alcoholic. She had no one to turn to but had grasped at a straw when she read C.A.L.M.'s ad in the personal column of the daily *News-Press:* "Is your child abused, neglected? Let us share your problems. Keep C.A.L.M. in mind. Call 963-1115 for help."

After an hour of talking, Ruth had regained her composure. She responded warmly to the listener to whom she had poured out her story. She learned about C.A.L.M.'s volunteers, who could visit with her once in a while, maybe stay with the children sometimes and let her get away to refresh her spirits. Ruth's response was eager and full of hope. She was promised a call from a volunteer the next morning. As soon as they had hung up, Mrs. Pike called one of C.A.L.M.'s twenty-three volunteers, a young mother herself, who had seven children and understood very well the pressures of motherhood. Mary Ligman took the case. She and Ruth met and formed a friendship which still exists. At first Ruth called Mary very frequently, and each time the sympathetic reassurance of her understanding new friend served to relieve her tensions. Mary invited her over to use her sewing machine to convert the pieces of material hanging at Ruth's windows into curtains. They took their children to the beach together to let them run out their energies in the sand. They had coffee together frequently and exchanged experiences about children and their lives. Ruth learned that the middle child she feared might be hyperactive seemed pretty normal compared to Mary's three-year-old twins. Mary encouraged Ruth to make new friends through Weight Watchers and Parents Without Partners. Through the help of a small, restricted private donor's fund for Child Care, C.A.L.M. was able to provide sitters while Ruth attended evening classes to brush up on her office skills. When her youngest child reached three years old, she went to work part-time to supplement her income. Both she and her children are benefitting from her new self respect and improved self image as a woman and a mother.

C.A.L.M.'s volunteers do not work in the office; they do not take initial telephone calls or evaluate cases, nor do they have any access to the confidential records of clients in the office. The two paid directors of C.A.L.M. share the every day, 24-hour, listening-evaluation of all new cases, and handle all calls coming into the "hot line" number with the assistance of a 24-hour answering service which cross-connects emergency calls after office hours or on holidays or weekends to the home of the director on call. The constant, frequently intense emotional demands of this work require an unusual degree of dedication, maturity and physical stamina from the directors and volunteers. Self-referred clients are told of the availability of C.A.L.M. volunteers and are encouraged to let a volunteer contact them. Only with the client's permission is such a contact made. From that point on, the volunteer is expected to continue helping the client in any way possible while a need for such help exists. A friendship is originated which has no artificial termination date pre-established. As the client's self-image improves and the scope of interests, friends and activities broadens, dependency upon the volunteer gradually decreases. Eventually, the client becomes self-sufficient enough to release the volunteer to begin working more intensely with a new client. No volunteer is ever assigned more than two clients at one time.

C.A.L.M.'s volunteer program is based on the concept of "Mothering" as defined by Dr. C. Henry Kempe and his staff and upon the need in every human being to feel a sense of being worthy and cared about in a consistent, meaningful way. Most of C.A.L.M.'s clients have never had anyone on whom they could depend consistently to answer their emotional needs. Frequently their emotional development has been inhibited. Many clients have experienced a series of rejections throughout their lives. C.A.L.M.'s volunteers provide caring friends who are nonjudgmental and dependable, who are available whenever the clients need help, and who are dedicated to preventing child mistreatment through their understanding, unselfish service.

Close cooperation exists between C.A.L.M. and other organizations in the community. All third party reports dealing with suspected or known incidents of mistreatment are referred by C.A.L.M. to whatever agency has the best professional facilities to answer the problems involved. Referrals are made to C.A.L.M. by other agencies when a preventive effort is indicated and physicians also use C.A.L.M.'s service frequently. During the first two years of C.A.L.M.'s existence, four hundred eighty-one cases were handled. Forty-seven percent of these were self-referrals. In most instances, the emotional problems involved indicate a need for professional counseling. Deep-seated emotional defects which have originated in the childhood of the client must be dealt with professionally before a cure can be achieved. Encouraging clients to seek help through psychotherapy is an important part of the listening, referral, resource service C.A.L.M. provides.

Approximately twenty-five percent of C.A.L.M.'s cases originate between 6:00 p.m. and 9:00 a.m. or on holidays and weekends. The value of having a listener available for emergency calls when other agencies are closed was dramatically demonstrated in a case reported on a Saturday evening. A concerned neighbor-informant reported a two-week-old baby boy in a severe state of neglect whose life, she felt, might be in danger. A week before, the mother had brought him home from the hospital. Since then he had cried constantly, was given a cold bottle of milk at infrequent intervals, and had not been bathed or had his clothes changed since he was brought home. A heavy, red rash had developed all over the child's body. The day after the mother came home from the hospital, she had attempted suicide. Friday night, her husband had been arrested for window peeping. She had visited him in jail on Saturday and returned home extremely lonely and depressed. The informant felt that the woman was too disturbed to be safely left alone overnight. She knew the wife had been under the care of a private psychiatrist but did not know his name. She did not want the wife to know she had called C.A.L.M. Through the sergeant on duty at the Police Department, the name of the psychiatrist was obtained from the incarcerated husband. The psychiatrist confirmed the gravity of the situation and authorized immediate hospitalization for the child and mother. He was able to talk the mother into going voluntarily. She was released in a few days, but her child was held through appropriate court action and assigned to a foster home until the mother regains her mental health through the help of extensive professional counseling.

Although C.A.L.M. deals with all calls for help, the most important goal is to PREVENT mistreatment by reaching out a helping hand to frustrated parents before they focus their anger on their innocent children. Child abuse is most often a vicious cycle, repeated from one generation to the next. C.A.L.M. is committed to stopping this cycle!

C.A.L.M.
P. O. Box 718
Santa Barbara, Calif. 93102

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Carole Johnstone, a graduate of Western Washington State College and Dominican College of San Rafael, California, taught at Washington State before becoming a Counselor at the Youth Guidance Center in San Francisco. She is the Founder and Director of Parental Stress Service, a hot-line for potential child abusers serving Berkeley and the East Bay.

PARENTAL STRESS SERVICE – HOW IT ALL BEGAN

By CAROLE JOHNSTONE

I am a single parent. I am divorced and have one son now 8 years of age. When he was two, my marriage began to break up and the pain, hurt and frustration I was feeling was vented on him. I wasn't aware of what was really happening until one day when Danny messed his pants and I exploded. I caught myself just as I was ready to ram his head through the floor. I left him there on the bathroom floor, shakily made my way to the telephone, called the one friend I had and asked her to come and take Danny for awhile. She was there in fifteen minutes. She asked no questions; she simply accepted me as a person and a friend. Because she did not condemn me as a person for having feelings of not wanting my son around, of not knowing how to cope with all the feelings going on inside me and because of her continued support and friendship, I was able to turn to her before things really got bad, and I was able to seek professional counseling.

Two and one-half years later, I moved from the small town we were living in to a large metropolitan area. I was struck by the complete aloneness one can live in, either by choice or by circumstance, and I began to wonder about other women who are under the pressure of being a 24-hour parent. Who could they turn to if they couldn't cope any longer? Could an agency be a friend they could call so the child wouldn't be injured? Or was I the only mother who felt that at times I couldn't take my son another minute?

I spent a year reading and studying child abuse and realized that 90% of such cases occurred because the parents were lonely, isolated, under a great deal of stress, or ashamed to admit they might have feelings of dislike for the child. They didn't feel free to call on family and friends or didn't have either close by. By now I was convinced that a private agency could function as a friend to help prevent child abuse, in its broadest meaning, from occuring.

Parental Stress Service was incorporated as a private, non-profit agency in March of 1972. We operate with a telephone available 24-hours a day, seven-days-a-week with a back-up team of volunteers who go to the home of the parent to give direct service. The direct service might mean providing a respite from 24-hour parenting, helping the parent find professional counseling, serving as an advocate for the family and/or as a friend. The volunteers are encouraged to develop a lasting relationship with the parents. We are also a referral service to aid parents in finding needed day-care as well as counseling. Here are excerpts from our leaflet:

When you call *Parental Stress Service*, you can find help in the following ways:

- An active listener . . .
  - pour out your anger, hurt, problems.
- A trained volunteer coming to your home . . .
  - to help work through a crisis;
  - to provide a respite from 24-hour a day parenting.
- Information and referral
  - to help you, a concerned relative or neighbor;
  - to help families in stress find longterm professional help.
- A speakers' bureau.

Specific Aims of *Parental Stress Service*:

1. Interrupt the cycle of child abuse If parents' needs can be met, the abuse might not occur and healthy child-parent relationships can be passed on to the next generation.
2. Aid caretakers of children who are afraid of losing control or who can't cope any longer.
   "Before the fact" helps reduce problems.
3. Direct people to existing agencies for long-term professional help.
4. Establish a 24-hour, seven-day-week program.
   A crisis can occur anytime.
5. Educate the general public on the problem of child abuse.
   Schools, groups, clubs, private practitioners are encouraged to ask for a speaker.

Not being connected with a public agency makes funding a little more difficult but being able to set your own policies, thus assuring anonymity (if desired) and confidentiality, which is imperative, makes the effort worthwhile. We do not have a switchboard but operate with one staff person who coordinates the program and volunteers and a 24-hour answering service. If no one is in the office, the answering service picks up the call and cross-connects into the home of the volunteer on call. A crisis call is defined as one in which the (1) caller sounds upset, (2) asks to talk with someone, *or* (3) won't give a name.

It has been an exciting year. There are moments when I am very tired and wonder if it is worth the effort, but then a call comes in and the parent says, "I don't know what I would have done if I hadn't been able to call," and the tiredness goes away!

Parental Stress Service
P. O. Box 9266
Berkeley, California 94709

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THE EXTENDED FAMILY CENTER

by Elsa Ten Broeck

he "battered child syndrome" became acknowledged during the 1950s as a recognizable and treatable entity. Usually, battered—or abused—children are first seen by a doctor or nurse when they are brought for treatment of injuries which range from bruises and burns to multiple bone fractures. Sometimes they are discovered when a parent brings a child to a hospital, well-baby clinic or other facility for examination or treatment unrelated to the non-accidental injury.

Recognition of the battered child is the first, crucial step in treating child abuse. Medical personnel have to maintain a high index of suspicion about how a child was injured because parents will rarely admit to abuse and children are generally too young or too frightened to tell what happened. When it appears that a child could not have received his or her injury accidentally, the doctor or clinic in all states is required to bring the family to the attention of the authorities, to obtain protection for the child and rehabilitation for the family.

In 10 percent of the cases of child abuse, professionals have found that long-term separation of parent and child is the only way to assure the child's physical safety.[1] For the remaining 90 percent, however, treatment can be offered to help parents understand and redirect the anger that is usually at the base of their abusive behavior and to help them improve their overall care of their children. The treatment is based upon our knowledge of the dynamics that cause adults to strike out against their children.

Child abuse is found in rich families and poor families, in families with one child and in families with many children, in families with one parent and in those where two parents are present. It occurs among all races and economic groups, and among the employed and the unemployed.

But there are some common denominators among cases of child abuse, factors that characterize abusive parents and their family situations. The dynamics that usually set abusive parents apart are the lack of positive mothering they themselves experienced during childhood, their own inaccurate perceptions of the child, social stresses within the family and, often, their belief that physical violence against children is an appropriate disciplinary action.

Most abusive parents were themselves mistreated as children and most never experienced the positive parenting that would help them later to love and nurture a child. As a result, these parents grow up to be deprived, needy adults. As parents whose own needs have not been met and who have seldom been recognized as individuals of worth, they find it difficult and sometimes impossible to tolerate the demands and needs of young children, demands and needs they really do not understand since they tend to view their children, no matter how young, as miniature adults, capable of adult reasoning and behavior.

Expecting that a child will care for them, rather than the reverse, is one example of how abusive parents share inappropriate expectations of children. Typically, they view their children as a source of love and support for themselves, and, in general, they expect even young infants to be quiet and neat and to hold still on command. When their children are unable to meet these unrealistic demands for mature affection and behavior, the parents become enraged. Their response is violent, as the response of their parents to them so often was.

In general, abuse of children is episodic, occurring at times of turmoil in the household. When parents such as those described above are

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Elsa Ten Broeck, M.S.W., is the director of the Extended Family Center in San Francisco, California under stress, the child often becomes the easiest target upon which to release their frustrations. Marital problems, financial problems, and sometimes even so trivial an event as a washing machine breaking down can result in a child being abused. Usually, these stresses are heightened by the isolation and lack of support experienced by most abusive families. Parents often act out against their child because there is nowhere for them to turn to relieve their tension or stress.

How Can Such Families Be Helped?

Our project, The Extended Family Center, was established with support from the Office of Child Development in February 1973 as a treatment center for abused children and their parents. Sponsored by the Mission Child Care Consortium, Inc., a Model Cities day care program that serves a multiethnic section of San Francisco, it is funded by OCD as a 3-year research and demonstration project. It also receives funds from the California State Department of Health and a private foundation, the Zellerbach Family Foundation.

The center is presently serving 25 families who were referred to us because the parents were unable to protect their children from physical harm. Some of the families were referred by the courts and six children are dependents of the court; other families were referred by public health, mental health and social welfare agencies, by the University of California Medical Center, and by private physicians.

Located in the old Mission District of San Francisco, the center has a full-time staff of 14: six staff members work with the parents, five with the children and three are involved in administration. In addition, volunteers and students come in to work with the children on a regular basis.

As indicated by its name, the center's purpose is to develop the resources of an extended family for isolated parents who are acting out through violence against their children. Since one of the most needed services for all the families is relief from 24-hour care of their child, the program includes day care services that give relief to the parents while helping the child.

The center is open from 9 a.m. to 6 p.m. and emergency telephone coverage is provided after hours. During the first phase of the project, when we were serving only 10 families, the children were cared for together, in the day care center on the first floor of our storefront building. (The second floor houses the parents' center rooms and offices.)

Parent Consultant

The recent acquisition of a second building has enabled us to treat the children in two groups. The original children's area is now an infant center serving children under 2½, while the 2½- to 5-year-olds are cared for in the second building around the corner. Separating the older children from the younger ones was advisable since the acting-out behavior of many of the older children was detrimental to the younger ones.

Treating The Children

We have found that all of the children who come to the center need specialized attention. At first, they exhibit behavior that is either very withdrawn or overactive. All are mistrustful of their environment and many are violent in their responses to both staff members and other children. Their mistrust is particularly apparent at nap time and in their fear of such routines as having their diapers changed. All have great difficulty falling asleep and need one-to-one attention to relax and rest.

As a result, the staff's initial involvement with the children consists of helping them gain trust in their environment. Our consistency, lack of pressure, and acceptance of regression help them to do this.

Most of the children in the program go through an initial adjustment period of four to six weeks, during which time their overactive or withdrawn behavior lessens. Limit-setting is particularly important during this period. Abused children have not been exposed to appropriate limits for their age and behavior and they desperately need them to learn how to relate positively to their environment. Thus, how we set limits is one of the most important aspects of our day care program, for it is essential that a positive way be found for these children to learn how to control their behavior. This is difficult because the children usually come from environments that demand unquestioning obedience in a manner that prevents a child from learning how to control himself. Once the children become more trusting (usually from one to six months after their admission to the center) the staff is able to help them utilize skills appropriate to their ages.

At admission, most of the children score below age level on the Denver Developmental Screening Test and the center structures an individual daily program for each child to help strengthen those areas in which he or she is behind. A primary difficulty for the child care staff has been to help these children, who have been continually exposed at home to inappropriate expectations, to develop their potential at their own pace.

We have found that the children, particularly the preschoolers, regress in the center. But once they find that limits do exist they begin to respond to more age-appropriate expectations. With the safety of their environment established, the children are ready to begin to take risks and explore learning with the staff.

Surprisingly, the children have had little difficulty adjusting to the differences between the center and home. Most of them are aware of what behaviors are allowed at the center and what is allowed at home. However, for those who had been most severely battered the discrepancy between home and center has been the greatest and we are watching to see what long-range effect this will have on them. It is our hope that the freedom of the center and the positive support the child receives will help him or her better cope with the limitations at home.

More challenging has been the need to help their parents accept and understand the kind of care offered by the staff. Parents have been particularly concerned, for example, about the lack of physical discipline in the center. Through frequent meetings with individual parents and teachers, and by the formation of a parent board to handle complaints not resolved individually, we have been able to help parents begin to accept and learn from the center's very different type of child care.

The use of day care for treatment of abused children is a new approach both for professionals and parents. As we had expected, in the beginning the parents were ambivalent about this care. On the one hand, they were relieved to be released of the daytime responsibility for their children; on the other hand, they were very threatened by the possible loss of control and/or love of the child. However, as the parents receive support from all the staff, they begin to relax and develop relationships with the teaching staff. Parental participation in programs for the children is encouraged and parents have helped paint the center and built play equipment for the yard.

Parent Treatment

Our philosophy of parent treatment is based upon the belief that the parents themselves, with support from professional workers, are the best source of treatment. Through the use of groups the staff helps parents give support and understanding to each other. Initially, the staff provided most of the direct help and treatment. Gradually, we have seen the parents themselves begin to offer advice, support and resources to each other. Parents often call each other when they are upset with a child or just want someone to talk to. If a parent is resisting treatment, another parent frequently will make contact to help the resistant parent work through his or her difficulty. The parent board meets weekly with staff to discuss problems at the center and all staff members and parents meet once every six weeks to talk over the program and any needed changes.

> ***I try to teach my fellow workers what it is like being on the other side... As for the parents I work with, I think that it helps them feel more comfortable with the Center in that they know that someone there has been through their situation and came out okay.***
>
> Parent Consultant

A vital part of the parent program is the role of the parent consultants—two formerly abusive parents who are employed as full-time staff. Both consultants are mothers who once abused their own children and are now not only able to provide good care to their families but can also act as liaison persons to help develop trust and communication between parents and professional staff. Their participation and openness about their own past abusive behavior has greatly lessened denial and hostility among the parents enrolled in the program and it has encouraged their cooperation and participation.

All parents are required to participate in four hours of treatment per week at the center. The treatment includes weekly group therapy led by a male social worker and female parent consultant. This group is a formal therapy session during which parents discuss the problems they are dealing with in their family situations. Topics discussed by the group have included marital and financial problems, feelings about children, early childhood experiences of the parents and the parents' abusive acts. The two staff members who lead the group also meet weekly with a consultant trained in transactional analysis, a technique they utilize in their assessment of the group process.

Parents also attend weekly occupational therapy meetings. This form of treatment, generally used with physically or emotionally disabled patients, has been extremely successful with abusive parents. It offers a unique means of assessing each parent's functioning and presents a concrete learning experience for him or her. In addition to these weekly sessions, each parent meets individually with the occupational therapist once every six weeks to discuss her assessment of the parent's work and behavior in the group meetings. Some characteristics of parents' behavior and functioning which the use of craft work as a diagnostic tool have revealed are: inability to complete projects, difficulty in relating to authority, unwillingness to try new things and lack of self-confidence or self-esteem. Through their participation in occupational therapy, parents have learned to understand their behavior better.

Emergency Service

The center also provides an emergency service for parental support after hours. A 24-hour-a-day, 7-day-a-week emergency phone line is available to the parents and arrangements can be made to care for children and families after hours in emergencies. We have found that the provision of such emergency care has been vital to the center's ability to protect children. Parents have learned that they have a stop gap for pressure that might otherwise have been turned on to the child. Emergency calls have varied from the need to relieve loneliness and boredom to a request to be relieved of the care of a child because the mother was losing control and was afraid she would hurt the baby.

Family Programs

The families served represent a spectrum of abuse—from cases where intervention is needed to prevent injury to the child to cases where a child has been severely injured and extensive work is needed to rehabilitate the family.

Ms. Gomez, age 23, and her 7-month-old child Maria, for example, were referred to the center by a local hospital because the mother had reported to a family health worker that she frequently left Maria alone and was force-feeding her and spanking her when she would not hold still while having her diapers changed. Upon admission to the center, Maria did not sit up or roll over, was very difficult to feed, and screamed constantly. The mother was a lonely proud woman who spoke no English. She was overwhelmed by the change in culture from Puerto Rico, from where she had emigrated several years ago, and she was particularly upset because she was not married to Maria's father.

A Parent

Ms. Gomez was very responsive to our program. She began attending English classes and became active in the Spanish-speaking parents' group. Through work with a male-female Spanish-speaking social work team, she was able to end her relationship with Maria's father, a married man, and began to develop more positive relationships with men. She also met regularly with the head teacher in the nursery center and began to learn more constructive ways of caring for her baby.

Maria, too, has made progress. Initially, she could only be comforted by rocking in a baby swing. Gradually she allowed staff to hold her and she became more involved in her environment. We found that allowing Maria to eat by herself solved her very difficult feeding problem. With staff support her mother was able to allow Maria to be messy while eating and she even became successful in feeding her.

Solving the feeding problem was a major step in improving the mother-daughter relationship. When allowed on the floor at the center, Maria quickly began to move about and she reached normal developmental milestones in about two months. At the same time, her mother began to take Maria out of her crib more often at home.

Now 18 months old, Maria is a happy, alert baby who is walking and beginning to talk. Her mother is also much happier and relaxed with her child and after 11 months in our center, the Gomez family will soon be graduating. Ms. Gomez plans to go to work and have Maria cared for by a babysitter. The center will help her carry out her plans.

Very different problems are involved in our work with the Smith family, which was referred to us by the Juvenile Court.

Elaine Smith was three months old when she was admitted to a hospital for treatment of fractured jaws, ribs and arms. Neither parent could explain the injuries. The hospital diagnosed Elaine as a battered child; her mother was arrested and placed on probation for child abuse. Elaine was placed with a relative for five months until our center opened. Upon the agreement of the parents and the Juvenile Court to work with the center, Elaine was released to her parents.

After initial resistance Mr. and Mrs. Smith became very involved with the center. They described it to staff as a "home away from home" and a central part of their lives. Both parents are active in the parents' group. Mr. Smith has joined the parent board and frequently helps staff with such jobs as painting, obtaining supplies, manning the telephones and greeting guests.

Elaine was extremely withdrawn when she first came to the center. She would sit and not move unless picked up by a staff member. She would become very anxious and unhappy when she was being dressed or undressed; she would not nap and rarely played with toys. Now, after 11 months in the program, she is gradually beginning to relax and is much more active. She plays easily but is quite violent towards other children, scratching and biting when she is approached.

Elaine has become attached to staff members and is eager to attend the center, but she continues to be very quiet when she is with her parents and usually appears quite fearful in their care.

Despite the Smiths' participation in the program, the staff has been unable to help them solve their primary problem, drug addiction. Through their involvement at the center both parents began to trust the staff enough to be honest about their drug usage and its effect upon their lives. With the help of the teaching staff, the Smiths finally admitted to the negative effects of their drug usage upon Elaine and they are beginning to struggle with the need to involve themselves in a drug treatment program. We have made it clear to both parents that unless they actively cope with their drug problem the center would have to recommend to the Juvenile Court that Elaine be removed from their care.

During the last two months both parents have sought help and Elaine's behavior has improved in the center. Both the Smiths and the staff recognize, however, that help from the center will be needed for a long period of time before Elaine will be totally safe in their home.

A couple whose family problems have been greatly alleviated by their participation in the center are the Goodmans. Both parents in this family have a history of deprivation and abuse in their own childhood. Their two children, Billy, aged 4 and Susan, 1½, were referred to the center by a local hospital because they had suffered many unexplained injuries at home. The family was referred to the Juvenile Court which agreed not to remove the children as long as the family cooperated with the center.

> *The staff is really warm. I was afraid to come here, afraid they'd take my little girl away. But they want to know how you feel. They don't turn you off. They really want to help. People said they would but I didn't believe them at first . . . The hot line here is really terrific for me.*
>
> **A Parent**

Mr. and Mrs. Goodman quickly indicated to staff members their need for marital counseling. Mrs. Goodman was excessively dependent on her husband and very jealous of the children. Mr. Goodman was also a very dependent person with no idea of how to care for the children and his helpless wife. He responded to the children as his parents had responded to him: expecting a great deal from them and beating the children when they did not respond.

Both parents have found a refuge in the center. Mrs. Goodman comes daily and works on a variety of projects. She is finding that she can be independent and a person of value separate from her husband and children. Mr. Goodman has found supportive help for his frustrations and alternatives on how to handle his anger.

Both children enjoy the center program and are beginning to respond to staff attention. Billy is now speaking and Susan, although very wary, is now playing with other children. The hospital staff had reported at the time of referral that they had never seen the children smile during any of their contacts with them. After three months in the center, both children smile and laugh easily and with enthusiasm.

To augment the more formal aspects of the program, each family is assigned an individual worker who is responsible for coordinating the center services with those provided by other agencies. All workers provide an atmosphere of nurturing and support that gives the parents the emotional resources they need to better care for their children.

This type of service is extremely demanding on staff. Rarely is it formal therapy that brings about changes in the behavior of abusive parents. Rather, we have found that it is the relationships between parents and staff and parents and parents that allow a parent to gradually develop the confidence needed to bring about the necessary change in his or her behavior.

Work with abusive parents requires the ability to give in a very total way to demanding, needy adults. The rewards in this type of work are not typical. Rarely does a worker get thanked or feel that he is directly appreciated by the families. However, the satisfaction of watching parents change and assume positive care of their children is an experience that brings rewards rarely found in any other profession. ■

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[1] *The Battered Child,* edited by Henry Kempe and Ray Helfer, University of Chicago Press, 1968.

WORKING WITH ABUSIVE PARENTS

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A Social Worker's View

by Elizabeth Davoren

Working with the problem of abused and neglected children means being a witness to the effects of violence and—sometimes—death. It means being involved in "parents' rights," "children's rights" and a diversity of views on how to bring up children. These loaded subjects stir the feelings of everyone involved. Reactions range from disgust ("How can anyone hurt a helpless little child?") to identification ("I've often felt like hurting my own child—I don't know what kept me from doing it").

People who identify strongly with parents have found one way or another to ignore child abuse: "It's none of my business," "It really didn't happen," "The child deserved it," "I don't know what to do about it" or "What good would it do to call someone?" People who feel strongly identified with children have also tended to ignore child abuse: "I can't stand to think about it," "It's really none of my business," "I don't know what to do" or "It won't do any good to interfere—it will only make the parents more angry."

The child abuse reporting laws passed during the 1960s are modifying some but not all of that resistance. When parents seriously hurt their children they arouse feelings of anger and a desire for revenge. Yet the fear that punitive action will be taken against parents—by calling the police, for instance—prevents large segments of the child population from being offered possible protection. The reason for this is that most people do not wish to subject parents—whom they see as just like themselves—to police, court or other authoritarian action.

This is why working with parents is becoming increasingly important. It is a proven way of protecting children while, at the same time, encouraging recognition of the child abuse problem. When parent and child are treated as a unit in need of help, rather than as wrongdoer and victim, there can be positive results from the recognition and report of child abuse. If reporting child abuse results in treatment, it is no longer perceived as a terrible action taken against the parent.

The child is also safer in every way when he or she is not made the adversary of the parent. The reality of court trials or hearings is such that their outcome may not result in child protection when needed. A child may be returned to a home where he has been abused and where the situation remains essentially unchanged. This doesn't mean that law enforcement is an unnecessary or undesirable tool in solving the child abuse problem. The problem could not be tackled as it has been without the backing of child abuse reporting laws and the use of the court system to enforce them. The police—in some cases the first outsiders to encounter child abuse and neglect—are extremely valuable allies in casefinding, and police help is needed to protect children in some families. However, no matter who the first contact person is, offering abusive parents help and understanding makes more sense than punishing them for what they usually consider to be the proper way to raise children—the way they were raised by their parents.

Why Child Abuse?

Parenting is learned, and battering parents have usually been taught some very potent lessons by their own parents.

- They learned that their survival depended on their ability to conform to their parents' wishes and to perform feats abnormal for their respective stages of development. For example, during infancy they may have had to learn not to cry, not to move while being diapered and not to reach for the spoon while being fed.
- They learned that not only would they *not* be nurtured or cuddled or handled lovingly, but that they were also expected to reassure and comfort their own parents—role reversal as it is called.
- They learned that no matter how well they behaved,

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or how much care they were able to provide their parents in this turn-about process, it was never enough. *They were no good and they deserved to be hit.*

- They learned that their parents could not see what they were like, how they functioned, or what their needs were.
- They learned that having children was a way for *parents* to be taken care of and loved.
- They learned that children must be punished to achieve desired results.
- They learned that the day would come when they could release stored up hostility without fear of reprisal.

All they had to do was to survive, grow up, and have children.

This destructive childrearing method, passed on from generation to generation, produces adults who, first of all, have an understandable stake in having children. They want children to provide for them what they tried to provide for their parents. They believe their babies will love them and make them feel better. Since they do not see babies as helpless, taking care of them is not an anticipated problem. The babies will behave, because they know how to make them behave. This misunderstanding of what a child's capabilities are, combined with a willingness to punish as severely as necessary to meet extremely high expectations, often leads to serious physical injury of their children.

Reporting the Parents

If reported for child abuse, these parents—who normally avoid contact with other people—are suddenly brought in touch with a lot of people with whom they have an extremely difficult time in relating. Their incredibly poor opinion of themselves, and their distrust of all others, make it hard for these parents to like or to be liked. They are also frightened and deal with their fright by either acquiescence or threats.

Their acquiescence, based on childhood experiences of being forced to meet parental expectations, is backed by extraordinary sensitivity to the expectations of others. They can be so skillful at saying what they are expected to say that it is often difficult to know when words have been put in their mouths. The parents' ways of meeting expectations result in differing opinions about what "abusive parents are really like," and it also makes workers feel they know or understand the parent better than they really do. This "trying to please" also leads to wrong impressions of the parents' improved child caring capability. One purpose of parents' acquiescence is to get people off their backs, so to speak, so they can live their lives without interference by others, bringing up their children in the only way they know how—by making harsh demands.

So much for acquiescence. Parents can also be very threatening, particularly when told they are being reported for child abuse. They feel blamed, picked on, and interfered with in an area that they regard as no one's business but their own—how to raise their children. Often workers can't help but feel accusatory or vengeful for what the parents have done to their child. They also feel uneasy about interfering in the time-honored sanctity of the parent-child relationship. This all adds up to a situation in which workers may find themselves confronted by people who don't like them, who are threatening them, and whom they find it hard to like.

Workers need to realize that in most cases threatening parents appear to be far more in control of the situation than they really are. Understanding and empathy go a long way toward reducing the parents' fright and, in turn, their anger. Questions like: "What did your child do that upset you?", "Is your youngster hard to handle?" and "Does your baby need too much attention?" can show parents that their feelings count. At the same time, questions like these help workers find clues to both parent-child interaction and the parents' need for help.

Another way of relieving tension around abuse reporting procedures is to make sure the parents have an accurate picture of what is going to happen to them. If there are specific people who can help them, such as a public defender, they should be told who is available. Offering practical and specific help in contacting family members, finding child care for other children in the family and obtaining transportation—or simply thinking through with parents how they can do these things—will help them be more open to treatment.

Treatment

The kind of help abusive parents have responded to involves relationships that are more intense and more personal than the usual professional therapeutic relationships. Some call it "reparenting" or nurturing. What it means in practice is fulfilling parents' needs in the following areas:

- Parents need help to feel good about themselves, to make up for the devastating belittling they've experienced in their own lives.
- Parents need to be comforted when they are hurt, supported when they feel weak and liked for their likeable qualities—even when these are hard to find.
- Parents need someone they can trust and lean on, and someone who will put up with their crankiness and complaining. They also need someone who will not be tricked into accepting their low sense of self-worth.
- Parents need someone who will not be exhausted with them when they find no pleasure in life and defeat all attempts to help them seek it.
- Parents need someone who will be there in times of crisis and who can help them with their practical needs, by leading them to resources that they can use or by giving more direct help.
- Parents need someone who understands how hard it is for them to have dependents when they have never been allowed to be dependent themselves.
- Parents need someone who will not criticize them, even when they ask for it, and who will not tell them what to do or how to manage their lives. They also need someone who does not need to use them in any way.
- Parents need someone who will help them understand their children without making them feel either imposed upon by having to understand what they cannot, or stupid for not having understood in the first place.
- Parents need someone who can give to them without making them feel of lesser value because of their needs. Parents need to feel valuable, and eventually they need to be able to help themselves and to have some role in helping others.

Worker Characteristics

Working with abusive parents is as demanding a job as the list of parents' needs implies. It requires workers who are themselves exceptionally sensitive to other human beings, who can accept hostility and rejection without being devastated by it and without feeling the need to retaliate. It requires workers who will not be critical of the parents' behavior and who can feel at ease with parents' criticisms.

It also requires workers who can share themselves without sharing their problems and who can befriend while maintaining awareness of their helping role. Workers must also be able to think first about the parents' needs and not their own, and they should have a sense of self-worth and achievement that will sustain them through work that is demanding and brings few immediate rewards.

Even when workers feel strong within themselves, and have reasonably fulfilling lives of their own apart from their work, the nurturing of abusive parents can be quite exhausting. The parents' needs are extensive—at times like bottomless pits. Workers calling on their own emotional resources are constantly aware of themselves, their own upbringing and the way they are raising their own children, if they have any. This awareness can be wearing. But the most draining part of caring for these parents is knowing that a child may be seriously injured or neglected, or even die, if the worker misjudges the parents' capacity to care for the child.

Workers' unreal estimates of how much parents have been helped and how well they are doing have sometimes proved fatal for children. Moving abuse cases from one worker to another, or one agency to another, has resulted in losing track of the cases—and in fatalities, too.

Some communities are using interagency committees or multidisciplinary teams to keep track of abuse cases, and to provide workers with a support system in making decisions on diagnosis, treatment and final disposition. The composition of such a team depends upon who deals with child abuse problems in the community, but in general the fields of medicine, law enforcement, education and social service are represented. Involving consumers—abusive parents who have had treatment—adds an important dimension to the team.

The teams provide interdisciplinary education for their members and can serve to educate the community as well. But most of all the use of such teams means that the workers who handle child abuse cases, and the agencies they represent, are no longer making what can be life and death decisions without others to help and share responsibility.

Workers need on-the-job support, too. Ways of providing such support vary from conventional supervision and staff meetings—where workers describe their cases, discuss their feelings about them and seek advice—to staff get-togethers where newer techniques of role-playing, validation exercises and facilitating are used to raise levels of consciousness and to allow group support for each worker who needs it. Some agencies also limit the number of child abuse families each worker may carry to one, two or three, with less demanding cases rounding out their loads.

Supportive Services

Supportive services now in use include homemaking services, emergency funds, emergency shelter care, 24-hour telephone hotlines, child day care, 24-hour crisis nurseries, parents' groups and visits by public health nurses. These help families directly and prevent the worker from having to shoulder all the burdens. Supportive services also bring more people into the lives of the families. This diminishes the need of the family to gain so much from one worker and, at the same time, enriches the family's life by providing new contacts and experiences.

Homemakers are ideal if they can cuddle the young and make them comfortable without freezing out the parent. Their role amounts to demonstration parenting. Done well, it gives the parents a feeling of being cared for, too.

Public health nurses, trained and given supervisory support, can be the primary workers in child abuse cases. A public health nurse can also function as the person responsible for keeping a very close watch over the children so that the family's worker can focus on concern for the parents. Health services are usually easy for the parents to accept.

A hotline, available 24 hours a day, 7 days a week, is a necessary adjunct of treatment.

Day care is one useful way of relieving the parent from too close contact with his or her child while at the same time providing more nurturing for the child. The day care staff can be strong allies of the parent's worker, if they have the time, capacity and know-how to help parents better understand their children. A staff that can also recognize the parents' capabilities is invaluable. Day care staff members, however, almost always identify so strongly with the children that being able to understand the parents' needs, and then to help *meet them*, is very difficult. Perhaps the most that can be expected of the staff is that it *not* compete with the parents for the child's loyalty, and that it *not* let the inevitable parent complaints about how staff members deal with the child threaten them.

Crisis nurseries can relieve parents by their immediate availability in times of unresolvable parent-child tension. They safeguard the child and allow parents distance and time to discover more about the source of their tension, be it the child or something else. A positive attitude of nursery staff members toward the parent helps, of course. Their concern is with the child, and asking them to do much for the parent in the temporary crisis situation is out of place. But alliances for abusive parents develop in unexpected ways, and with each exposure to a person who might want to help comes the possibility of the parents finding the kind of support that is right for them.

Emergency shelter care deals with parent-child crises without separating parent and child, since a shelter will have a full time staff to care for the child if necessary. Rarely available, emergency shelter care is ideal. It can allow the parent to separate from the child for part or all of the day, whichever seems best, but it does not make complete separation necessary as a part of relief and treatment. A shelter staffed by treatment people can observe crisis behavior and either intervene when necessary, at an especially meaningful time or, in less threatening situations, allow the crisis to run its course.

Parents groups provide the opportunity for parents to get together to share their frustrations and to support each other, usually under the guidance of trained leaders. Most groups are mothers' groups. Some mothers are experimenting with including older children in their groups. Fathers are often overlooked. They tend to be less available because they work and because childrearing is traditionally thought to be woman's work. Many fathers will not involve themselves in therapy, which they see as a put-down. If there is some way they can be involved as decision makers, their participation is more likely.

Emergency loans "put one's money where one's mouth is." This is an extremely important attitude in our culture. Being able to give money can mean handling stress situations which have no other solution. It establishes the worker as a person who is sensitive to the "real" needs of the parent and it can also reinforce the parent's feeling of being nurtured in ways no other service can.

These are a few of the supportive services that can help both parent and worker. Others, not listed here, can be adapted to the needs of abused children and their families.

By sharing the know-how of child abuse treatment with staff members of various community services through seminars, training programs or written material, we can expand the growing list of facilities that can help the abused child and his or her parents.

Meeting the Parents

When the parent's first contact is with hospital trauma workers or protective service workers who are trained to understand abuse and neglect, intervention has a more useful beginning. Offering help to people who don't believe there is such a thing, or don't believe they need it, requires more than an average amount of skill. If the worker who does the reporting or takes the complaint to the parents is also to treat the parent, he or she will need even more skill and much more self-assurance.

Being able to stay with the parent throughout the reporting process, and going to court with them when that is necessary, can strengthen a *relationship*, provided this is done well and with sensitivity to the potential for parental acquiescence. Having one worker report and a different worker treat has the advantage of giving parental resentment a focus outside of the treatment relationship. But parents who are forced to see many people in the course of referral for child abuse, and to go through their story over and over again, are likely to be much harder to reach with an offer of help. To take an extreme situation—but one that actually happens—parents may be seen first by an emergency room physician, who has seen the injured child, then a medical social worker, who prepares them for the fact that the injury must be reported, by a policeman who responds to the report that has been made, and then by a juvenile police officer, a probation worker and a protective service intake worker—all before being assigned to the protective service worker who will continue seeing them. Even if all people interviewing the parents are understanding, it takes a lot more strength than most people have to go through all those explanations and interviews. Such "institutional abuse" of abusive parents is a poor way to get started.

Beginning Treatment

Being able to reach out to parents is an essential part of treatment. In many situations the first thing parents need is someone who is willing and able to go to a lot of effort just to see them. Home visits are not only useful in themselves, but may be the only way workers will get to see the parents at all—at least in the beginning. With parents who avoid involvement by disappearing when the worker is expected, or by hiding and not answering the door, or by focusing their attention on television during the worker's presence, patience and persistence are important. Going back again and again, insisting upon contact of some sort, is often necessary with these parents. Being able to offer the specific practical help already mentioned under supportive services is a meaningful way to start, but such help may not be available.

Sympathetic, responsive, non-judgmental listening is an extremely valuable service. People who have never been listened to before will find it hard at first to believe that anyone is interested in what they have to say. Convincing parents that talk is useful is a tough way to have to begin a treatment that uses talking as its main tool, but it can be done. Friendly chatting is an icebreaker.

Workers need to find their own ways of relating to parents because genuine, honest, forthright behavior is the only kind that means anything to them. Such parents quickly spot pretense. When a parent feels threatened or angry or distrustful, or all three, the reaction may be hostile silence. A sincere worker may be genuinely ill at ease and find it hard to think of what to say. But it doesn't matter if the words seem silly or not right because wanting to do right is what comes across. The important point is that parents matter: they are a necessary part of the program and will determine what happens in treatment and its outcome.

Showing honest respect for the parents and their capabilities helps put parents at ease and parents need to feel at ease if they are to engage in a useful dialogue. Information given by parents early in the contact is often unreliable. For one thing, these parents have been wrongly perceived so often by their own parents that they are confused about themselves. They "misperceive" themselves, so *to speak. Furthermore*, when they *don't trust their workers* —and they usually don't—incorrect information may serve as a camouflage and a protection from feared punishment. Or they may simply be trying to say what they think they are supposed to say. When two workers are seeing the same parents they are often astonished by the different impression each gets of the parents—based on the completely different stories parents tell them. As parents feel more trusting, talk becomes more useful to both parent and worker and what is said is usually more realistic.

There is no orderly progression to treatment. Much needs to be worked on simultaneously. For instance, exploring what parents want for themselves and for their children can be done more successfully after parents feel more trust. However, exploring what parents want shows them that their opinions matter, which in turn helps them develop trust.

In the beginning abusive parents are less likely to know what they want to accomplish for themselves because they don't believe they are capable of doing anything. They usually wish passively, but without much hope, to have things done for them. They will say that they want their children back—if the children have been placed—no matter how they feel about placement. They will wish for a better place to live or new clothing or a vacation. But beneath these layers of wants or desires lie others. For example:

- A mother of two repeatedly injured, poorly cared for children had been raped by her father when she was 10. Years of promiscuity followed, then prostitution, then procuring, then prison. Actually, she wants a kind of respectability that will allow her to approve of herself. She wants her marriage to be monogamous and her family to be respected in the community.
- A mother of four was adopted when she was young by parents who later totally rejected her. She wants to be able to give up one of her children, toward whom she alternately feels murderous rages, apathy and guilt because the child continuously reminds her of her inability to cope with certain aspects of her life. She has to know her child will not be rejected by adoptive parents.
- A brain-damaged mother of two children, abused by her own mother and father, wants to be able to function as a reasonable, competent adult. Among other things, she wants to learn to read.

- A father of two, brought up in an orphanage and beaten there, wants to feel more comfortable with others. He needs relationships with people who will understand his need to depend on others.
- A mother of three, who has been brain damaged by child abuse herself, causes her own child to have a fractured skull. She wants to learn how to mother well and to bring up her child herself.
- A mother of two children finds comfort in a life without children and would like to place them permanently, something she can only seek to do after she is able to accept her desire without feeling guilty about it and without being fearful of social ostracism for not wanting to raise her children.
- A mother brought up by a grandmother, because her own mother beat and neglected her as a child, loses her first baby. Child abuse is suspected. A second baby is injured shortly after birth. Now, the mother wants no children under age five to care for. She wants to be alone with her husband and she wants her mother to care for the baby.

Parents who are beginning to take their own needs seriously can begin to think of their children's needs. But before they reach that point they will need some special care.

A Declaration of Dependence

Encouraging parents to depend on the worker is a key part of the reparenting process. Dependence sometimes frightens workers. They see themselves being used up, or they fear they will have to take care of the parent's overwhelming needs forever. Some treatment approaches have even emphasized the importance of self-reliance. However, abusive parents usually have a lifetime of unsuccessful self-reliance behind them. As children they were used to taking care of the adults in their lives, as well as having to take care of themselves. If not helped out of old habits, they can neither care for children nor seek worthwhile self gratification. Dependence allows parents the nurturing that permits them to grow.

The more people involved in nurturing parents the better. Parents who are together in groups can do a great deal for each other. They feel more comfortable with each other and they are more readily available to each other. When groups exist and parents can use them, they provide a tremendously important adjunct to therapy, or therapy itself. The most devastated parents, however, need help before they can join a group and almost all parents need individual attention in addition to group help.

Services come in handy when meeting dependency needs. Tender Loving Care — TLC — Transportation. Lending money. Child care. If services are not available elsewhere and workers are able to give some of these services themselves, it can be well worth the time. Chauffeuring, for instance, is considered nuisance work by many, but some of the best interviews take place in the casual giving atmosphere such service creates.

Parents' self-esteem is increased by the caring process. Having their needs met says to them that they are important. If there is no way to give services, or they are not required, there are other ways to communicate care. Being on time for appointments, for instance, even with parents who forget appointments or are not on time themselves, tells them they matter in a way that no words can.

The Next Step

As parents begin to feel worthwhile, as they begin to trust and depend on their workers, they tend to be more honest about their feelings. They also feel more friendly toward their workers and others. This is a good time to find ways of helping them include more people in their lives—if they haven't already done so on their own. They may be able to do more for their children, though they may complain more about the children at the same time. Complaining is one way to release angry aggression—usually a much better way than has been used in the past.

Questioning parents about their children—what they expect of and want for them, what changes they notice in them, what they enjoy most about them and when they feel most stumped about knowing what to do with them—will give the worker many clues. Parents who are ready to explore these questions are often at a stage when they can allow their children to be more dependent, while at the same time demanding less from them. They are also ready for their children to have more people in their lives. In other words, the children can have something for themselves, without the parents feeling excluded or put down. Giving parents specific information about child development and what they can realistically expect of their children is useful at this stage. Telling them how to take care of their children is another matter. Respecting parents' ways of dealing with their children is not always easy. This does not imply that workers should ignore or accept abusive behavior. Although the feelings that cause a parent to abuse a child are accepted and understood from the beginning, their acting on those feelings is clearly not acceptable.

With support and acceptance, parents' threshold of anger may be lowered appreciably. This can result in their being less angry with their children. If at the same time aggression can be funneled into productive, even pleasurable, activity that is even better. Workers, of course cannot do this for parents, although they can let parents know what resources are available to them. As all other people, abusive parents have ups and downs, some of which are totally dependent on events over which they have no control. Although poverty is no direct cause of child abuse, money crises—as other crises that make parents feel helpless and powerless—can result in child abuse. At times of severe crisis, a drop-in nursery, a shelter home, or an emergency foster home may be the only way to prevent child abuse.

Conclusion

Although the success of treatment will be judged by what happens ultimately to the abused child, the protection of that child will depend upon the well-being of the parents or caretakers. This is why the treatment efforts described here have focused on the parents and their need for support and understanding.

The desire to punish parents who have abused their children, particularly when the abuse is severe, dominates those who do not understand the causes of child abuse. Understanding is necessary not only of the parents, but of the workers as well. The capacity of workers to deal with the difficult problem of child abuse will depend on their individual strengths and the support of their efforts by a system and people in the social service and other systems who are not consumed by the pressure of power struggles. As Desmond Morris points out in *The Human Zoo*:

> "The viciousness with which . . . children . . . are subjected to persecution is a measure of the weight of dominant pressures imposed on their persecutors." *

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* *The Human Zoo* by Desmond Morris, Dell Publishing Co., 1971.

Foster Placement of Abused Children

by Elizabeth Davoren

Foster placement has often been the only resource available to protect children who are at risk. However, while foster placement at its best can be a very important treatment resource, it has its disadvantages.

For a child who is old enough to be aware of his surroundings, removal from home and placement with a stranger can be very frightening, more frightening often than the unstable or threatening home he or she knew. In addition, a family whose relationships are already very troubled is more traumatized by enforced separations than most families would be. Later, when children are returned to their home after the separation, they may be scolded or punished for behavior which the parents then see as caused by the foster parent. If the children have identified with the different values of the foster home they are rebuked for that, too. In fact, when foster parents are underpaid and overworked, what help they can give to a child, short of prevention of severe physical and nutritional injury, may not be enough to make up for the damage caused by the separation.

One problem arises because foster parents usually pride themselves on taking better care of a child than the child's natural parents. This concept, understandably gratifying for the foster parents (sometimes making up for poor pay and long hours), can be very disruptive to the natural parent-child relationship. It reinforces the parents' poor image of themselves in the very area where better self-concept and performance are essential: namely, child care. There is every reason, however, to believe that foster parents can take just as much pride in helping the child and parent get on better with each other. Instead of being cast in the role of a separating person who nurtures the child and regards the parent as an intruder, the foster parent can be nurturer for parent and child and a model for good parenting.

Another problem is that foster parents are often especially curious about the details of physical abuse and natural parents are—understandably—unhappy to have such information shared. The more severe the abuse, the harder it is for the parent to admit his role and talk about it. By providing information about the parent and his personal hardships, the protective service worker can redirect the foster parents' curiosity to the source of the trouble and enlist their help. Getting the natural parents to share some of their personal problems with the foster parents can also bridge a large gap. The story of Erica and her daughter Jennifer illustrates how, at its best, foster family care placement can help both parent and child.

Throughout the court hearing and all the interviews such intervention entails, Erica had maintained that the cause of her 5-month-old daughter's severe injuries was unknown to her. She considered the psychiatrist and social workers assigned to "help" her unfair, unfeeling and useless, and she was not able to benefit from the contacts. In the meantime, Jennifer was placed in a foster home. At first, Erica avoided the home because she was ashamed and afraid of what the foster mother would think of her. Her husband George did not visit either, feeling little attachment to the baby and no responsibility for her care. But Erica began to worry that she would be thought an unfit mother for not visiting and so she did. To her surprise, the foster mother was a sympathetic person, who talked with her about the baby's behavior, not about what Erica "had done." The foster mother, who liked to sew, made a kerchief for Erica and she invited Erica and George for meals from time to time. Soon her parents began to give Jennifer her baths and to do other things for her. These activities not only helped them feel closer to Jennifer but also relieved the foster mother of much of Jennifer's care. As soon as possible, Jennifer went home for visits. Gradually, the home visits lengthened until she was able to be home for good.

Jennifer's return to a safe home was expedited by the protective service worker's ability to support the foster parents in doing what she could not herself do to help parents and child and by the relationship that developed between the foster parents and Jennifer's family. The active and close contact maintained between parents and child during placement and the generous spirit of the foster parents, which led them to share the warmth of their home, their skills and, most of all, the care of Jennifer with the parents, was a crucial factor in returning Jennifer to her home. ■

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Working With Abusive Parents

A Psychiatrist's View

by Brandt F. Steele

Brandt F. Steele, M.D., is professor of psychiatry at the University of Colorado Medical Center and chief psychiatrist at the National Center for the Prevention and Treatment of Child Abuse and Neglect, Denver, Colorado.

The following article is excerpted from the forthcoming OCD booklet, Working with Abusive Parents from a Psychiatric Point of View *by Brandt F. Steele, M.D. The booklet is one of a series of six being published by the National Center on Child Abuse and Neglect for use by professionals, community leaders, national organizations and others concerned with child abuse and neglect.*

The actions of parents or other caretakers which result in abuse of infants and children do not fall into any standard diagnostic category of psychiatric disorder, nor should they be considered a separate specific psychiatric disorder themselves. Yet to consider child abuse as a derailed pattern of childrearing rather than as a psychiatric disorder does not mean that abusing or neglecting parents are free of emotional problems or mental illness. They may have many psychiatric disorders, much the same as the general population.

Abusing or neglecting parents have about the normal incidence and distribution of neuroses, psychoses and character disorders which exist rather independently and separately from the behavioral patterns expressed in abuse of their offspring. Such psychiatric conditions may warrant appropriate treatment in their own right regardless of the coexistence of patterns of abuse.

There is a small group of abusive parents (less than 10 percent of the total) who suffer from such serious psychiatric disorder that they may be either temporarily or permanently unavailable for treatment of the more subtle problems of abuse. Among such conditions are schizophrenia, serious postpartum or other types of depression and incapacitating compulsive neuroses, with or without phobias. Ideally, such persons should be screened out of the regular treatment program and given inpatient or outpatient care as necessary. Also in this group are those parents who suffer from severe alcoholism, abuse of narcotic and non-narcotic drugs or from significant sexual perversion, and those who have been involved repeatedly in serious antisocial violent or criminal behavior. Such troubled persons need much more intensive, prolonged psychiatric care and social rehabilitation than can be provided in the usual child protective program. Until such measures have been accomplished, it is futile to try to alter the pattern of abuse.

It is obvious, then, that psychiatric consultation should be available in all situations where workers are dealing with the problem of child abuse and neglect. Proper psychiatric screening procedures ensure that the most troubled parents will receive the appropriate type of care and also protect workers from spending enormous amounts of time and energy on problems which require other special kinds of intervention. Working with such disturbed parents should never be delegated to the usual worker in child protective agencies. It is unfair to child, parent and worker, and the results are usually unhappy for all concerned.

A few words must be said about the socioeconomic status and racial background of abusing families. Unfortunately, because so many of the early reports and descriptions of child abuse came through welfare agencies and municipal hospitals it became a common belief that abuse and neglect of infants were associated with racial minorities and poverty-stricken groups of people. Such ideas still persist in many quarters, despite the increasing knowledge that child abuse and neglect occur among families from all socioeconomic levels, religious groups, races and nationalities. These facts should not be interpreted to deny the profound effect which social and economic deprivation, housing problems, unemployment, and subcultural and racial pressures have on the lives and behavior of the caretakers who abuse and neglect their children. Any stress can make life more difficult, and the ramifications of poverty can make anything worse than it would otherwise be. Such factors may be, and often are, involved in one way or another or in varying degree in many cases of abuse. They must be considered in every program of treatment of the families in which abuse occurs and appropriate actions and remedial measures undertaken through social case work, psychotherapy, counseling, vocational rehabilitation, financial aid, or any other method available to the agencies involved with the family.

A word of caution is appropriate, however: no matter how necessary and useful it might be to improve the socioeconomic status of parents, this should not in any way be confused with treating the more deeply seated personal character traits which are involved in abusive behavior. It is well recognized that individual acts of abuse may occur when the parents are faced with a crisis in relation to finances, employment, illness and so forth, but such crises cannot be considered adequate causes for abuse. Crises of this kind are equally common in the lives of many people who never display abusive behavior and, on the contrary, abuse can occur in families who are wealthy, well educated and well housed. The role of crisis as a precipitating factor in abusive behavior is an important one, however.

Working With The Parents

The first task faced by all those who try to work in the area of child abuse, regardless of professional background or lack of it, is that of coming to peace with one's own attitudes toward the problem of abuse and neglect of infants and small children. It is very emotionally disturbing to see a seriously injured or neglected baby, and we usually respond in either of two ways when confronted with the situation. We may disbelieve that such a thing could actually be true. We deny that parents could really have attacked their own offspring and that some other explanation for the situation must be found. Alternatively, if we do believe actual facts of what has happened we tend to have a surge of righteous anger and feel disposed to scold and punish the parents. Obviously, neither of these attitudes is useful in trying to do something to better the situation and help the parent improve his method of child care. Denial precludes any chance of dealing with the problem, and long experience of many people has indicated over and over again that criticism and punitive attack of the parents have adverse effect and no real therapeutic value.

Most useful in eliminating to the highest degree possible an attitude of anger toward the parents is a knowledge of how the parent's own life and difficulties help in understanding why he happened to become an abusive parent. Probably the thing which is most helpful in producing an understanding non-punitive stance in the one who is working with the abusive parent is to realize that one is not working with an abusive parent as much as one is working with a grownup person who was in his own early life a neglected or abused child himself. This one basic premise is probably the most important thing to keep as an organizing principle in the back of one's mind as one is trying to understand and work with abusive parents, regardless of one's own professional training or type of approach.

Characteristics and Problems of Abusive Parents

For most abusive parents their immaturity and dependency is essentially functional in nature and related to the emotional deprivation endured in early life. Hence it can be remedied to a significant degree by more rewarding and more satisfying experiences in adult life, especially those occurring during carefully managed therapeutic working relationships. However, it is necessary to keep in mind another cause for the inadequacy and inept parenting behavior. A small but significant number of children who were abused or neglected in their earliest years suffered organic brain damage due either to head trauma or to malnutrition during critical growth periods. As a result they had perceptual defects, diminished IQ and significant delay in language development. These deficits may produce in later adult life a condition characterized by significant lack of basic knowledge and attitudes of helplessness, immaturity and dependency.

If such organic causes of difficulty are suspected by the worker, careful evaluation by appropriate psychological testing and psychiatric examination should be undertaken. Such parents who are organically impaired will not respond easily, if at all, to the usual methods of working with abusing parents, whereas those whose immaturity and dependency are essentially functional in origin are much more responsive to interventions. If parental dysfunction due to brain damage is documented, therapeutic goals can be appropriately revised and limited, thereby preventing the expenditure of much unproductive effort by the worker.

The Constellation of Psychological Characteristics

No two abusive parents are exactly alike, of course, but in general all of them share certain characteristics to some degree in a variety of combinations. The main components of this constellation of factors involved in abuse may be summarized as follows: the special form of immaturity and the associated dependency in its various manifestations; the tragically low self-esteem and sense of incompetence; the difficulty in seeking pleasure and finding satisfaction in the adult world; the social isolation with its lack of lifelines and reluctance to seek help; the significant misperceptions of the infant, especially as manifested in role reversal; the fear of spoiling infants and the strong belief in the value of punishment; and the serious lack of ability to be empathically aware of the infant's condition and needs, and to respond appropriately to them.

The cumulative effect and dynamic interactions of these various factors make it extremely difficult for the parent to maintain equanimity and be successful as he or she tries to meet the demanding tasks of child care. The daily care of infants and small children requires large amounts of time, physical energy and emotional resources. The caretaker needs to have much patience, ingenuity, empathic understanding and self-sacrificing endurance—the very things which we see tragically lacking in abusive parents.

These parents have never had their own needs satisfied well enough to provide the surplus which would enable them to give to the infants under their care. With good reason they often doubt their own ability to do even a minimally acceptable job and they do not know where or how to seek help. In contrast to averagely successful parents, they do not have an adequate support system of spouse and extended family, or helpful neighbors, friends, pediatricians and so forth. Probably most important of all, they do not have a background of life experience which has enabled them to get pleasure out of life and to trust other people. They have no storehouse of spare emotional energy but live a precarious hand-to-mouth emotional life, without a built-in cushion of hope, or available contacts to tide them over tight spots and crises. It is because of this that crises are crucially important in the lives of abusive parents and are often the precipitating factor in single events of abuse.

Treatment Modalities

The matching up of parent, worker and treatment modality is difficult and usually managed on a less than ideal scientific basis. Abusive parents are unique individuals, often with great reluctance to become involved in any form of treatment. Hence the type of treatment may be selected under great influence of what the parent will go along with at the given moment, rather than because of any theoretical preference for a specific method. It is equally true that the selection of a worker or a mode of treatment will be influenced by availability rather than theoretical principles. There is at present no data derived from thorough comparative studies which indicate how or why any one modality of treatment is more effective than another for particular kinds of parents. It is known, on the other hand, that even in the face of rather haphazard selective mechanisms, remarkably good results have come for parents who have been treated by many different methods.

By far the greater part of the burden of caring for abusive parents is carried by public and private social agencies. Although the traditional values and methods of social case work are maintained in such agencies, there is also an increasing use of other techniques and of paraprofessional workers under supervision. Social workers in health-based child protective services have also been active in developing innovative techniques of working with abusive families and social workers in many different kinds of programs have been active in developing services and training people in the areas of lay therapy, parent aides and homemakers.

Many different modes of psychotherapy have been used in the care of abusive parents and their families. A few parents have been successfully treated by classical psychoanalysis, but the general character structure and lifestyle of most abusive parents make this procedure quite impractical and probably unsuccessful. Psychoanalytically oriented dynamic psychotherapy in the hands of skilled experienced therapists has been extremely successful in many cases. With most abusive parents, the therapist must be more willing to adapt to patient needs and to allow more dependency than is ordinarily considered appropriate. Intensive psychotherapy which skillfully utilizes the transference, with avoidance of the development of a full transference neurosis, can stimulate great growth and deep structural change in these patients despite their severe immaturity and developmental arrest. In general, abusive parents respond best when psychotherapy is accompanied by supportive adjuncts associated with a cooperative child protective service or provided by individual social workers, lay therapists or group therapy. Skilled and experienced psychologists can also work successfully as counselors and therapists in both individual and group situations.

There is increasing use of group therapy as a mode of working with abusive parents, but as yet there is a dearth of published reports describing fully either techniques or long-term results. Groups may be composed of the single parent who has done the actual abusing or of mothers or of couples. Most groups are formed and led by professionally trained group therapists such as psychologists, psychiatrists or other mental health workers, although social workers in protective agencies have also taken up this pattern of treatment. It is thought by some that it is always wise to have at least two leaders, preferably a man and a woman, and especially if there is an attempt to develop a couples group the leaders must be male and female. A rapidly growing and extremely important movement is the development of self-help groups formed under the titles of Parents Anonymous and Families Anonymous. Organized on a voluntary basis by abusive parents themselves, with sponsorship and guidance from a professional worker, these groups provide a haven of safety and help for people who might otherwise be unable—out of fear and anxiety—to relate to any other kind of treatment program. After some time of working in such self-help groups the participants may be able to enter into other more extensive programs.

For those parents who have the courage and ego strength to enter into group programs, the process helps them express their emotions more openly, and also to become desensitized to criticism. They find out they are not alone in their troubles and their self-esteem is improved. As an especially important benefit the group provides channels for developing contacts into the wider community, first with group members and later with others, a kind of relationship in which the abusive parent has been woefully lacking. Experience suggests that even though group therapy may be the chief mode of treatment involved in caring for abusive parents, it may not be sufficient by itself. Contacts outside the group, either with group leaders on an individual basis or with other workers from other agencies or disciplines, are often necessary for the patient's best development and improvement.

Couples groups can help solve the common difficulty of getting both spouses involved in treatment. Husbands are notoriously reluctant to get help, but the presence of male workers leads some of them to accept either group or individual treatment programs. It is important for both partners in the marriage to be involved in rehabilitative efforts if at all possible, regardless of which one was the actual abuser. Abuse is always, in part, a family problem with one parent actively abetting or condoning the abusive behavior of the other, even though not actually participating in the abusive acts.

Behavior modification techniques have been used to obtain changes in the attitudes and actions of abusive parents in a relatively short time. Whether this technique has validity for long-term rehabilitation is not yet clear.

Other modes of dealing with abusive parents have used "role modeling" and techniques derived from learning theory. These modes are at least partly based on the assumption that the parent is in difficulty because he has not been given proper opportunity and material to develop adequate parental attitudes and actions. To some extent this is true, but these modes are based essentially upon the provision of material for cognitive learning whereas the deepest deficit in abusive parents is in the emotional or affective sphere. There is apparently a small group of parents who are neglectful or only mildly abusing, who can profit by the chance for cognitive learning of good parental techniques. However, the fallacy of believing this can be a standard method is demonstrated most clearly by the fact that in many cases, even those of serious abuse of a child, the parents are able to take care of other children in the family perfectly well. It is evident in such situations that it is not lack of factual knowledge which hampers the parents but the emotional difficulties involved with specific attitudes and misperceptions of the parent toward an individual child.

Psychiatric understanding of the tragic long-term troubles of abusive parents can provide a perspective on the place which child abuse takes in their lives, and their attempts to adapt to their world. It offers a rational framework which enables workers from many disciplines—and who use various modalities of treatment—to help parents grow and to develop new and better patterns of childrearing. The most valuable ingredients, over and beyond intellectual insight, which enable parents to grow and develop are the time, attention, tolerance and recognition of the worth of an individual human being which the worker can provide. ■

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WORKING WITH ABUSIVE PARENTS

A Parent's View

An interview with Jolly K. by Judith Reed

What I can tell you is what you won't get from the other speakers—the guts of a person going through child abuse. Being there doesn't automatically make you an expert on child abuse but it tells what it's like . . .

"Child abusers are going through hell. We have a vision of how powerful our anger can be, a concept of where this anger will take us if we are pushed too far, and the constant dread that we will be pushed that far. For abuse is usually not a singular incident but part of a consistent pattern . . .

"We don't like being child abusers any more than society likes the problem of abuse. If a positive approach is offered abusers, they will usually respond . . .

"I'm convinced that parents are aware of their feelings and let others know. But we don't know how to listen. Too many of our parents have told society time and time again: 'Help me! I'm at my wit's end. Help me before I bring my kid there too!' How can we learn to listen and respond? Too many parents are afraid to go to agencies because they fear that their child will be taken away . . .

"Our defense mechanisms may make it difficult to read us but look to see what went into our lives to make us this way . . . It's true that we're socially alienated, most of us with good reason. Ninety percent of us were abused as children. I can remember not being loved when I was a child. But I just thought I was a rotten little kid and that's why I was being tossed from foster home to foster home. Since most of us grew up viewing others as part of negative, hurtful relationships, why should we form more relationships now? . . .

"The feeling parents most often talk about in P.A. is fear—fear of what they're doing, fear of what will happen if they don't get help and fear of what will happen if they do. And, of course, their fears are reality-based.

"Many of us in P.A. also have a constant dread that our behavior is indicative of insanity, that we are losing our minds. We think: 'I had no control over a lot of things in my life and now I have no control over even my mind!' Many times we also work in symptoms that we have read about—game-playing, attention-getting. Then comes fear that we really are that psychopathic . . .

"I've abused my child physically and emotionally. Now I can talk in retrospect. I live in bits and pieces of those feelings now, but not the hell!"

* * *

The speaker is Jolly K., graduate of 35 foster homes, former abusive parent and founder of Parents Anonymous, Inc. of Los Angeles, California, a private organization of self-help groups that now has 1,500 members in 150 chapters in the United States and Canada.

Jolly is speaking to one of the many professional and lay citizen groups she addresses across the country each year in her role as director of programs for the organization—workers in state departments of social services and other agencies involved in the problems of child abuse and neglect, delegates to child welfare conferences, researchers and advisory groups.

Jolly founded her organization, first known as Mothers Anonymous, in 1970. It happened, as she tells it, in response to her bitter complaints to her therapist that there was no place for fearful abusers—and potential abusers—to turn for services. "Well, why don't you start one?" was his answer.

In 1974 Parents Anonymous received a grant from the Children's Bureau, OCD, to help establish additional chapters—by preparing and distributing materials on the organization and by providing technical assistance to communities wishing to form such groups, including the training of regional coordinators and local group leaders.

How is a P.A. chapter formed? Who are the parents who join such groups? Who leads them and what do they do in their meetings? To find out, CHILDREN TODAY discussed the following questions with Jolly K.

CT: *How do your members learn about Parents Anonymous?*

Jolly K.: Surprisingly, over 80 percent of our members come by themselves after hearing about us on television or radio programs or through newspaper stories and other published materials. The remaining 20 percent are referred through agency contacts, the courts, mental health practitioners and friends, neighbors or relatives.

CT: *How does a new chapter get started and where may a chapter meet?*

Jolly K.: New chapters are the direct result of someone's dedicated interest coupled with his or her willingness to work in developing the chapter. Chapters may be started by a parent with an abuse problem or a professional or a service agency wishing to help such parents. More specific information on starting a chapter is contained in our new *Chapter Development Manual.**

A chapter may meet in any non-threatening environment, such as a YMCA or YWCA, church, school or community center. We definitely must not meet in a city, county, state or Federal agency such as a Department of Public Welfare, Bureau of Adoptions or police department. Because feelings like "I have to have a clean house" and "Those kids better behave" can lead to potential pressure situations, we do not recommend that chapter meetings be held in private homes.

CT: *Are most of your members parents who have abused their children or are a good proportion mothers or fathers who fear they may? What percentage of members have had a child removed from their home?*

Jolly K.: The majority of P.A. parents have already experienced the anguish of having an active problem, but we are beginning to see more and more parents become involved prior to actual abusive behavior. By the end of 1976 we expect to have more concrete information on this. We also will be gathering data on the percentage of parents who have children in placement.

CT: *Who, besides parents, are involved in the chapters?*

Jolly K.: All chapters have a Sponsor and Chairperson. The sponsor should be a professional who has a profound respect for the self-help concept and understands group dynamics. Our sponsors include psychiatrists, psychologists, marriage and family counselors, social workers, ministers and others. If a sponsor is already employed by an agency that has an authoritative position in regard to parents with abuse problems, such as a protective service agency, he or she must work with P.A. autonomously, not as a representative of the agency.

The chairperson is always a parent. He or she may be the parent who helped start the group, or one of several who worked to form the chapter and who was later chosen informally to serve as chairperson by the other parents.

Many of our chapters also have various volunteers working with and for the chapter. Babysitters who care for the children during meeting times constitute the largest number of volunteers. We also have volunteers who help by providing transportation, hanging P.A. posters, circulating P.A. literature, making public contacts on our behalf and raising funds.

CT: *What is the relationship between a P.A. chapter and the national organization?*

Jolly K.: The National Office is committed to provide chapters with the support necessary to start and maintain a P.A. chapter. This is accomplished primarily by providing literature, public exposure, technical assistance and consultation. An individual chapter is autonomous in most things; however, each is part of an overall national movement and receives support from the National Office. The main benefit, of course, is that there is strength, encouragement and unity in numbers, so that no one chapter is left with the overwhelming sense of responsibility, of "having to do it all by themselves."

CT: *Can you tell us something about what happens at a meeting?*

Jolly K.: Meetings begin and take shape in many different ways. Sometimes they start by someone saying, in response to the body language of a member, "Hey, what's happening?" Other times it begins by picking up on a problem a member was discussing at the last meeting or by asking for follow-up on a phone crisis call.

If I were at a meeting of a new group I might say, "Look, we're meeting here for a purpose—we're here to talk about what's churning inside us. Let's do something now to stop this behavior." We'd exchange telephone numbers and addresses and begin to form a lot of support contact.

I remember one meeting when a member, Lenny, was sitting on the couch, sharing with us how "down" she felt. Questioned many times as to the whys and wherefores, Lenny answered by saying, "I don't know," "I'm so confused" and "Stop badgering me." All the while she was quietly crying. She appeared so vulnerable, so young at that moment and most of all, so very needy.

I reached out, put my arms around her, practically putting her into my lap as if she were a lonely, lost child. At this, Lenny cried openly, much in the same way that a hurt, pained child cries. We as a group then knew, and verbally discussed the fact, that there are times when our need for nurturing exceeds our need to know the whys and wherefores. We also found out that when this overwhelming need is fulfilled—for Lenny it was within a half an hour's time—we can then turn our attention and response to the realities of our daily situations. Most of all, we learned that we can ask for inner fulfillment, that some others will respond with positive methods to help, and that we are not bad, unloveable people.

Another typical moment came at a meeting when Joel told other members: "I did it! Last week," she said, "I got so teed off at my son!" (He is five). "But instead of abusing him I squashed the milk carton I was holding until the milk went all over the place . . . I released my anger in a more positive way and it worked. Now I know I can do other things besides being abusive when I'm uptight."

Sure, the members laughed, but most important, we learned. Joel had shown us that a potential abusive situation can be averted, that we can be non-abusive regardless of how uptight we are! Call these heavy times or light times in a meeting. More than anything else, we in P.A. call the meetings "our time." The times with Lenny and Joel were very real moments in Parents Anonymous.

CT: *How do members support one another between meetings and in emergencies?*

Jolly K.: My last answer illustrated support but also a lot of caring. Suppose Joel had not squashed the milk carton. Alternate ways to release angry feelings include calling another member and releasing the feelings over the phone. Joel could also have asked another member to care for her boy until she "pulled it together," or she could have asked to have someone care for her (meaning stay with her) for a while.

CT: *Is P.A. the sole source of help for most of the parents involved, or are some also receiving treatment or therapy through another source? And is therapy suggested and/or provided with the guidance of P.A.? For example, do some chapters use the services of professionals, such as psychiatrists, etc?*

Jolly K.: Many of our members are receiving services other than P.A. and, yes, P.A. supports and suggests other therapy alternatives. On an as-needed basis we utilize the advice and input of professionals other than our chapter sponsor.

CT: *Do many parents drop out of the program? And if so, for what reasons?*

Jolly K.: Some members drop out after realizing that a group situation isn't their cup of tea. Others find P.A. uncomfortable for them. Also, some drop out by choosing to use other treatment resources.

CT: *Have you found that there are certain kinds of parents with whom P.A. cannot work successfully? Are you able to guide them to other help?*

Jolly K.: We've not found "certain kinds" of parents that we're not able to work with. We have found that some people find our program to be less successful for them. Again, we're not the "cup of tea" that they find comforting. When we are made aware of this, yes, we usually are able to guide them to other helping resources.

We have also found that persons who are acutely mentally ill and who come to a P.A. meeting may find that the group can't offer them the comprehensive services they need. It may also be that the group feels it is not prepared to deal with the behavior that may arise from their illness. In such cases the group, with the assistance of the sponsor, is able to refer the person to a more appropriate source.

CT: *What is the rate of recidivism for those who attend meetings? Do you follow up former members?*

Jolly K.: Recidivism has been very, very low. In the five years of the program's existence, we know of only two incidents which resulted in a child's hospitalization. That's not to say all is sweetness and roses and that our members have become "instant Pollyannas." It is to say that life- or limb-threatening abuse has been vastly reduced.

No, we do not do a formal follow-up on former members.

CT: *Do you feel that members of P.A., who have voluntarily sought help, are typical of most abusive parents?*

Jolly K.: Yes . . . emphatically, yes. We are seeing much the same, and then some, of the parents so often described in the available literature and research studies. We are seeing the very withdrawn, the very aggressive, the isolationist, the uptight, the psychotic . . . in short, we are seeing human beings displaying a lot of different "typical human traits."

CT: *How many members meet in an average group and how long do most parents remain members?*

Jolly K.: Average group size is between six to 10 members, with most members staying in for one or more years.

CT: *What is the percentage of men to women in your groups?*

Jolly K.: Too small a percentage. The average among the groups would probably be 25 to 30 percent men. Confirmed percentages are not currently available.

CT: *Do both parents in an abusive family usually attend meetings? And what have you found the role of the non-abusing (passive) parent to be?*

Jolly K.: No. Again, this is not one of our most successfully realized objectives. Incidentally, we've found the passive parent to be not so darn passive as people think. We know that a whole lot of "behind the scenes setting of the stage" is going on and contributing to the activeness of the active abusing parent.

CT: *Is dependency on the P.A. group a problem for members who must leave for one or another reason? Is any follow-up provided for those who do move away?*

Jolly K.: Dependency can be and is a problem when a member leaves the group. But then the P.A. program is based on the premise that we, as members, will work towards resolving our problems, including how to handle relationships that are broken. The only follow-up provided is whatever is asked for or through the suggestion that a departing parent get involved with a chapter in the city he or she is moving to. If none exists, parents are encouraged to start one.

CT: *What action is taken if the group learns that a member has committed an abusive act or fears that he will?*

Jolly K.: Group peer pressure, group commitment to work extra hard with the parent and, as an extreme last resort, if P.A. doesn't work and the parent doesn't stop, then with or without the parent's agreement other people will be asked to intervene and provide services that will guarantee the safety of the child or children and the parent. ■

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* A copy of *Chapter Development Manual* and other material produced by Parents Anonymous, including a general information flyer on child abuse, are available from Parents Anonymous, 2930 W. Imperial Highway, Suite 332, Inglewood, California 90303.

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Child Neglect: Reaching the Parent

ABRAHAM LEVINE, PH D

Although it has been a serious problem throughout the ages, only recently has child neglect been dealt with legally in any extensive manner. Since the mid-1960's, virtually every State and jurisdiction has legislated against both it and child abuse, but particularly the latter.

What is neglect? To some extent, it defies exact definition, but it may be regarded as the failure to provide the essentials for normal life, such as food, clothing, shelter, care and supervision, and protection from assault. The following areas are covered: physical (food, shelter, clothing), emotional (mental health), medical (diagnosis and treatment), educational (does not meet State law), moral (exposure to corrupting influence), community (does not provide adequately for children).

Although much has been written on the subject, there are no firm statistics of incidence. A survey of expert opinion places the number of neglected children at about 500,000 per year in the U.S. The maximum estimate is 2,000,000.

Child abuse, on the other hand, generally is a more dramatic condition that is mentioned here because of its relationship to neglect. It also has poor incidence statistics. But authorities estimate that child neglect occurs between 2½ to 20 times more frequently than child abuse. Lack of reliable reporting statistics on a national scale as well as definitional problems cloud the picture in both of these conditions. A ballpark estimate used by one authority is 200,000 per year.

Treating neglect is to an extent dependent upon the ability to understand and reach the parent who is responsible. The research that is described here concentrates on this aspect of treatment. Its results are to be found in a handbook for child welfare workers that was developed through an SRS-supported research project (89-P-80055/4). Most of the material was gathered in Appalachia, using the case-study or clinical approach.

Project Findings

The types of personalities observed most frequently among neglectful mothers are the apathetic-futile, the impulse-ridden, the mentally retarded, the mother in a reactive depression, and the psychotic. Many common characteristics are shared in the first three categories listed, and this is reflected in the literature.

The majority of neglectful mothers are poor. A woman in better economic circumstances can afford a caretaker for her children. Abusers, on the other hand, while they may cluster at the lower end of the economic scale, are found in all class levels. Also, there is probably a substantial minority of parents, although not poor, who are neglectful in the psychological sense. These people are less apt to be reported.

According to Dr. Norman A. Polansky, project director, the symptoms of apathy-futility are difficult to distinguish from depression. In depression the client may express anguish, but she does have feelings. In apathy-futility, however, there is a numbness, a defense that allows her to avoid being hurt. Nothing is worthwhile and, consequently, she cannot show love or real anger. Severe apathy-futility may also easily be confused as mental retardation. Through simple conversation, however, the fact of nonretardation might be discovered. Asking the person to write a communication is also another way of establishing that retardation is not the case in point.

The apparent signs that a mother is impulsive are more clouded than those of the apathetic-futile. This woman may be completely adequate in most respects. Thus, she may prepare balanced meals for her family; if asked, she can give appropriate answers to a questionnaire about child-rearing practices.

Although she may know better, she succumbs to uncontrollable, impulsive behavior. She may "take off" on an escapade for a week or longer. Her sojourn may be either with her husband or her boyfriend. It matters little. The impulse to do is stronger than her willpower. Or she may go on a buying splurge that costs a whole month's income. Stability, then, in this case, can be tolerated, but it is not long before an impulse has her diverted in a completely different direction.

Newspaper reports of children who "just wandered away from home" or who were "burned to death while the mother was off visiting nearby" are often the result of impulsive mothers who acted on sudden impulse to leave the home without proper regard for the safety or whereabouts of her children.

The apathetic-futile and impulsive mothers are most commonly neglectful of their children. Although the feeble-minded, reactive depressive, and psychotic—generally schizophrenic—are encountered less often as neglectful parents, their symptoms are so pronounced that they are readily recognized as such by the trained social worker.

Implications for Action

Skill in handling neglectful parents takes years of learning and practice. There are some generalities, however, that can be helpful when treating cases of child neglect. Perhaps the most important is to recognize that there is no single or royal road to successful casework with these women. Often, the treatment of preference consists simply of sitting with the woman and "talking out" her problems.

The pursuit of adequacy must be a goal of anyone trying to intervene in the life-style of these mothers—the lessening of infantile behavior. But rarely does an immature client sustain progress and growth without backsliding from time to time. One must expect to treat the neglectful mother through good times and bad, until the gains are well consolidated and she functions at a "normal" level for months.

The alteration of the client's living circumstances can be influential in helping her overcome neglectful tendencies. In using this tact, however, the woman's psychological makeup may not be altered in as rapid a fashion as her material circumstances, so that backsliding is an ever present factor to contend with. Continuing support is needed until the changes in her life style have become a way of life.

In making the initial contact, the social worker should first express concern about the mother, then the child. This is an important though seemingly insignificant point. In addition, the social worker should use tact in approaching these mothers. Even so, if the mother is not apathetic, she may express anger, usually at the complainant. Do not argue, it will clear the air for her to get her feelings out in the open.

Try to open up communication. Ask her: "Do you feel we are butting into things that are none of our business?" It is not as necessary to answer an attack as it is to hear it out. A practical hint: When dealing with a childlike and manipulative person, it is a good idea not to take her more seriously than she takes herself.

An *accusation* of child neglect must be verified by the social worker because it may not in fact exist. In this case, of course, the social worker will report the facts as observed. On the other hand, the worker may determine that the mother is untreatable and as a result recommend the removal of the children. In the latter case, removal of children would be recommended as a permanent solution. Removal, however, may be recommended on a temporary basis when it is perceived that the mother's treatment will be prolonged or if the removal itself may serve as a motivation for the mother to change. A child should not be removed unless there are overriding reasons that supersede the trauma of removal.

Neglectful mothers, regardless of the psychological diagnosis, are simply immature people. This fact cannot be overstressed. Treating such people requires a willingness to get involved in what the worker might consider a "messy" life. She must be willing to bear the hostility of these women.

Dependency needs must be met. Since the women already are dependent, it may be necessary to encourage them temporarily to center this dependence on the worker. Verbal honesty and directness on both sides must be increased to achieve this involvement.

Other factors, particularly family planning, are also important, as well as home management and proper budgeting. However, the psychological part of the picture requires the most effort, and it is emphasized.

Implications For Research

The development of valid early warning signals is an area in which research is needed. For example, mothers who receive poor prenatal care are known to be among the "population at risk." Many more variables must be identified. A known source of these valid warning signals is locked in the minds of experts who deal with child neglect. Therefore, a "brainstorming" session with assemblies of these experts might yield much useful information.

The prevention of child abuse and neglect is an area in which information is inadequate. Plans call for the undertaking of a research project to test the effectiveness of specific services designed to prevent neglect or abuse resulting from conditions which have been identified as "early warning signals." This research will also utilize the results of a survey of expert opinion regarding early warning signals.

Based on its findings, the researchers expect the following to be developed: 1) a consensus of most likely symptoms of potential child abuse and neglect, 2) a testing of these assumptions, and 3) findings on treatment measures to prevent abuse and neglect. Service models will be developed and States and local agencies will be encouraged to provide preventive services based on these guidelines. Where research is concerned, it is important to consider both abuse and neglect. Care must be exercised in differentiating between the two.

Since legislation has been effected against child abuse and neglect throughout the U.S., the next logical step to be undertaken is prevention before the fact and treatment after the fact.

Cost-Benefits

According to estimates, the taxpayer pays about five times more to maintain foster care than it would cost for natural family care in a low-budget home. There are no reliable cost data available for supportive services directed at keeping the natural family intact. But the costs are presumably much lower than those for foster care. At any rate, this is an area which bears investigation since foster care costs are in excess of $600,000,000 nationwide and much of it can be saved if child neglect were better detected and treated.

Dr. Levine is responsible for child welfare research and demonstrations in SRS. This paper is based on a handbook developed for social workers. The handbook was developed in an SRS-supported research and demonstration project. It is entitled, *Child Neglect: Understanding and Reaching the Patient*, and it is available at $3.50 per copy from: Child Welfare League of America, Inc., 67 Irving Place, New York, New York 10003. (The authors are Norman A. Polansky, Christine De Saix, and Shoma A. Sharlen. Much of the theory may be found in *Roots of Futility* by Dr. Polansky, *et. al.*)

Why Most Physicians Don't Get Involved In Child Abuse Cases and What To Do About It

by Ray E. Helfer

I want to outline eight reasons why I feel physicians are truly reluctant to become involved in the area of child abuse and neglect and then summarize a proposal as to how to gradually overcome this problem. Perhaps the best way to begin is by setting forth some facts, which I believe many physicians—and others—are not familiar with.

- Did you know that a 16- or 17-year-old adolescent girl who runs away from home—who has no place to live and no job—will be able to get help much more quickly from a Department of Social Services if she is pregnant?
- Did you know that a mother who is receiving AFDC support and who has her child removed because of the possibility of child abuse or neglect loses all form of support when the child leaves her home?
- Did you know that most communities have no long-term care facilities for parents who are abusive and/or neglectful of their children? And that Child Protective Services in most communities offer crisis-oriented programs, generally with rules indicating that workers can only follow patients for three to six months?
- Did you know that many abusive mothers have great desires to become pregnant?
- Did you know that lawyers, doctors and social workers receive little, if any, training in the areas of family law, early child development and child abuse programs during their formal education?

Nevertheless, the following facts are also true.

- The incidence of child abuse and neglect in the State of Michigan, for example, is one percent of the population of children in that state.
- Siblings of abused and/or neglected children are also at great risk.
- In approximately 10 percent of all emergency room visits by children for trauma-related purposes, the trauma cannot be explained by the parents.
- Child abuse programs in the Armed Services are essentially nonexistent except for a few isolated areas of the country.
- The turnover for Protective Service workers around the country is 40 to 50 percent and such large cities as

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Detroit, Michigan and Columbus, Ohio do not provide the Department of Social Services with legal services for their social workers.

- The death rate of physical abuse among children is approximately three to four percent and the permanent injury rate approximately 25 to 30 percent unless treatment is initiated quickly.
- In 1972, 2,300 cases of child abuse were reported in New York City. Eight of these reports came from private physicians.

These facts present some very troubling issues and problems which need to be resolved. I would hope they gain the attention of physicians and others. I would now like to review some of the reasons for physicians' reluctance to become involved.

Eight Reasons for Minimal Involvement

Medical school training was insufficient. Most physicians in practice were given minimal training in the areas relating to child abuse and neglect. We, as physicians, were not told about the dynamics of abuse, nor were we given any information about long-term treatment programs. For the most part, these data have been developed over the last 10 years, and many medical schools, even today, are not teaching about family dynamics and the interaction between parent and child in "normal" situations, much less in abnormal ones. Consequently, we have a group of physicians currently in practice who have been insufficiently trained and who, unless they have kept pace with current thinking in this area, are not up-to-date. While a physician may know a good deal about physical injuries that a child can incur, and the treatment for these specific injuries, some of the subtleties of the problem of abuse and neglect may not be understood. This lack of content material is a critical gap in our knowledge base.

Physicians are not trained in interpersonal skills. Only a handful of present-day medical schools are taking the time to train their medical students in the area of interpersonal skills. Even fewer schools were doing this some years ago. All doctors can think of experiences that illustrate this gap in training. When I asked a nurse, "Can you give me an example of how physicians have trouble with interpersonal skills?" she said:

"I overheard a mother talking to the neurosurgeon about her child who had fallen and suffered a head injury. The neurosurgeon said to the mother, 'If there are any changes in the child, I want you to call me.' The mother replied, 'What kind of changes should I look for?' His immediately reply was, 'Don't worry; if they happen, you'll know it.'"

In response to the same question, another nurse said: "My 17-year-old boy had a car accident not long ago and

The Child Abusive and Neglecting Pattern*

In order for a child to be physically injured or neglected by his parents or guardian, several pieces of a complex puzzle must come together in a very special way. To date, we can identify at least three major criteria.

First, a parent (or parents) must have the potential to abuse. *This potential is acquired over the years and is made up of at least five factors:*

- *The way the parents themselves were reared, i.e., did they receive a negative "mothering imprint?"*
- *Have they become very isolated individuals who cannot trust or use others?*
- *Do they have a spouse who is so passive that he or she cannot give?*
- *Presence of a poor self-image.*
- *Do they have very unrealistic expectations for their child (or children)?*

Second, there must be a child. *As obvious as that might sound we point it out because this is not just* any *child, but a very special child—one who is seen differently by his parents; one who fails to respond in the expected manner; or possibly one who really is different (retarded, too smart, hyperactive, or has a birth defect). Most families in which there are several children can readily point out which child would have "gotten it" if the parents had the potential. Often a perfectly normal child is "seen" as bad, willful, stubborn, demanding, spoiled or slow.*

Finally, there must be some form of crisis, or a series of crises, that sets the abusive act into motion. These can be minor or major crises—a washing machine breaking down, a job lost, a husband leaving, no heat, no food, a mother-in-law's visit and the like. It is most unlikely for the crisis to be the cause for the abuse, as some would like to believe; rather, the crisis is the precipitating factor. The simplistic view that child abuse is caused by parents who "don't know their strength" while disciplining their child has been shown to be false.

It is this combination of events that, when they occur in the right order and at the right time, lead to physical abuse.

was in a cast for three months. The cast came off and he limped badly. I took him to the orthopedist and said, 'I'm worried about his limp.' The orthopedist's comment was, 'You may be worried, but I'm not.' " The mother did not know whether the orthopedist was not worried because he was not the one who was limping or because he thought the boy would get better.

Another example occurred at the University of Colorado when a student was being videotaped during an interview with a mother regarding her school-aged child. The student asked, "Everything is going along all right at school, isn't it?" The mother said, "No." And the student immediately replied, "Tell me about his cough."

Limited training in the area of interpersonal skills makes physicians most uncomfortable in dealing with difficult situations, as when they are confronted with children whose parents may have been abusive or neglectful. Many of these parents are not easy to like and talking with them may well be very difficult. Most of the parents find it hard to look directly at the doctor or to show their appreciation for any interest he expresses in them. They often use phrases and language that may well be misunderstood. It is not easy to communicate with these parents even with the best of skills and the utmost training. Having minimal training in this area puts most physicians at an extreme disadvantage.

Doctors have great difficulty working with members of other disciplines as peers. Let me review why this seems to be the case. Most physicians decided to go to medical school about a year or two after entering college. We then embarked on a 3-year pre-medical program and, after getting into medical school, continued a 4-year training period. After graduating and receiving our M.D. degree, we had a 3-year residency. We, therefore, had approximately 10 years of very isolated life, having minimal communications with people outside of the medical field. Suddenly we find ourselves in a world that calls us "Doctor" and puts us on some kind of a pedestal. This makes it difficult because we have never been trained to deal with other professionals as peers, and so we withdraw behind our "Doctor" shield and maintain our isolation by becoming very busy.

The field of child abuse and neglect demands that doctors deal with nurses, social workers, court people, police, lawyers and others as *peers*. We, as physicians, are very uncomfortable in a setting that puts us in this position. This should be understood as not being a conscious behavior; rather, it is part of our "rearing." We, like the parents we are trying to help, have been trained in a very isolated system.

The drain on time, finances and emotions for the physician in private practice is truly extensive. Physicians who are busy in practice do not have the time to drop everything and run off to spend eight to 10 hours with a family during an acute crisis centering around the problem of child abuse and neglect. It is next to impossible to have 30 to 40 patients waiting to be seen in the office and be asked to stop all office activity and spend four to five hours with a child—who has been admitted to the hospital with an acute problem—and his family. We find it difficult enough to spend this time when we have had training in the area which has precipitated the crisis. Asking a physician, for example, to go to the hospital to care for a child with acute meningitis is a little bit more realistic because our training has given us the background and experience needed to handle this difficult problem. But asking us to go to the hospital, or some other place, to do something for which we have had little training and experience is unrealistic.

Being unable to care for the office patients is only one of the many difficulties that arise. Getting sufficient money to "pay the rent" for a case of child abuse or neglect is equally difficult since third party payment systems do not give us the kind of remuneration that is necessary for the amount of time spent. For example, for seeing a child in a child abuse case, Medicaid, Blue Shield or some other source is charged approximately $40 to $50 for the consultation. But after I spend approximately 30 minutes with the child, I then spend four to five hours over the next two to three days with the parents. In some difficult cases, I have spent as many as 40 hours dealing with a serious problem. It is most difficult to get reimbursed for this amount of time expenditure. The busy practitioner not only fails to *make* money, he is also unable to "break even" because of the high overhead of his office which usually remains open while he is spending time in the hospital with the family in crisis.

The drain on emotions is equally as serious. The problem of child abuse and neglect is life-threatening; both death and permanent injury are seen all too often. If correct decisions are not made and a full assessment of the environmental situation in which the child is living is not forthcoming, the physician will not be in a position to feel comfortable about the decisions made in regard to long-term care. This creates an emotional burden that is most uncomfortable.

Physicians have a fear of testifying in court, part of which is justified. Most of us have never been trained to assume this role. The only times we think about court and legal involvement usually is in relation to the issue of being sued for malpractice. This is a very significant fear. Some tell us not to be "up tight" about testifying since the Juvenile Court setting is not as formal as others. However, we have fears about going to Probate or Juvenile

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We, like the parents we are trying to help, have been trained in a very isolated system.

Court too because we do not understand the workings of these courts and are not prepared to wrestle with the questions of an astute attorney who may "wish to rake us over the coals." I believe requesting such testifying is analogous to asking a physician to do his own cardiac catheterization without ever training him in this skill. We would never think of asking one to do this, and yet we do ask an inexperienced physician who has never been in court to testify.

For example, a lawyer once asked me, "Did you examine the child completely?" Now think for a moment about that question. A "yes" answer would set me up for a barrage of picayune questions, one of which would surely be deadly. On the other hand, an answer of "no" would make me appear rather ridiculous. If one has experience in testifying in court, the stance that must be taken is to pause, look nervous, act flustered and then with great confidence say, "My examination was sufficiently complete to permit me to make my decision." Then the lawyer will pause, look nervous and act flustered.

There is minimal personal reward and these rewards are hard to identify. Abusive families are isolated, distrustful, frightened people. They don't know how to give feedback to those who work with them. They don't expect people to help them. These parents find it hard to show up on time, to pay bills, to smile or to say "Thank you." And, of course, if things go wrong, you know they may beat their child again.

One of our parent-aides put it very clearly when she said, "You know, this mother doesn't do anything for me. She doesn't smile, she doesn't call me, she doesn't say thank you. She doesn't do *anything.*" And a nurse in Chicago once told me, "I would be happy if at least this mother would get out of bed when I come to see her." My comment was, "Be happy she's at home."

The main things we look for in handling difficult cases are rewards and feedback. Parents who are abusive have never learned how to respond to help offered, much less to do something as a positive reward for someone. These families are very difficult, even when one is able to identify the minimal rewards that do come eventually, such as showing up *almost* on time, seeing a faint smile, phoning with a question.

When one does get involved he or she is often confronted with a community service system that is less than helpful. Follow-up is minimal; long-term therapy may be nonexistent. It often seems as if *no one is doing anything* and, even worse, no one seems to trust each other. Somebody has to get the service system coordinated, yet who is supposed to do it? This leads to the final point.

Physicians have rarely been trained to see themselves or to act as agents for change. We are a conservative group, resistant to the concepts of change, unwilling to make waves, and uncomfortable if others around us are anxious to make waves which may disrupt our lifestyle. There are some noted exceptions, some very capable doctors who are agents for change. For the most part, however, physicians are not about to try to bring about changes in the community. Physicians may feel threatened by the requirement that they report suspected abuse or neglect, particularly if their livelihood depends on a positive image and referrals. But the law requires that a report be made, and a few doctors have lost legal suits for *not* complying.

All this is somewhat analogous to telling doctors, "There is a state law that requires you to go off and listen to a large number of children to see if they have heart conditions." We say, "Well, that's not so bad." Most of us have been trained to listen to hearts and to determine if major heart disease exists. You then tell him, "Also, the state law requires you to report your findings, and if you think there is need for an x-ray study, you have to do it; a cardiac catheterization, you have to do that; surgery, you have to do that also." The doctor will say, "That's ridiculous!" and he won't comply. We have placed physicians in an almost impossible situation and consequently they are most reluctant to become involved, much less act as an agent for change to rectify many of the problems.

What Can Be Done

I have three recommendations to help alleviate this difficult dilemma.

- *All physicians must be trained* in the area of child abuse and neglect. Every residency, whether it be in pediatrics, family medicine, obstetrics, internal medicine, neurology or surgery, as well as every undergraduate educational program (i.e., medical schools), needs to include learning experiences in child abuse and neglect during this critical period of formal education.
- In addition to this general education, *we must train specialists in pediatrics* in the area of child abuse and neglect. These specialists would acquire the extensive knowledge and skills necessary to work with these difficult families.
- *These pediatric consultants must be subsidized* and affiliated with a community and/or hospital-based, multidisciplinary child protection team.

My feeling is that general training, in medical schools and residencies, should be incorporated into the existing educational program. This would be in the form of didactic material, case discussions, provision of ongoing care to certain families, and so on. There would be no significant difference in the overall educational format in teaching the *general concepts* of child abuse and neglect as compared with difficult problems in any disease. However, our specialists would also need to acquire certain basic skills and concepts in normal early child development and to understand how these basic sequences of development are modified both positively and negatively by parents and teachers. Extensive training in interpersonal skills is critical for these specialists. The typical pediatric training program does not provide this type of training, and yet without such an in-depth knowledge and skills specialists in child abuse and neglect will be severely limited. Training programs in this field must include course work in early child development, the acquiring of interpersonal skills and counseling methods, extensive experience with the effects that trauma and neglect have upon the *growing* child and, finally, methods of implementing change within his or her community.

This pediatric specialist in child abuse and neglect would have to be subsidized. As with most other specialties of pediatrics, the time needed to spend with a given family, to care for a child, to do specialized diagnostic procedures, to counsel the parents and to participate in conferences and case discussions with other professionals prevents the fee-for-service system from supporting this endeavor. There are few pediatric specialists who can provide comprehensive services to children and their families, regardless of whether they are in neurology, nephrology, cardiology or the like without some form of subsidy. The child abuse and neglect specialty is no different.

The Physician as an Agent for Change*

The cause of a very serious, life threatening disease is known and treatment programs which can be effective for some 70 75 percent of these families are available.

And Yet,

Our "Delivery of Services" system is not implementing what can be done.

Physicians have the capability of influencing this system and making it move from single disciplines working in isolation to a trusting multidisciplinary community program.

And Yet,

Around the country the cry is, "Physicians just won't get involved!"

All physicians who work with any family member need to know the basic causes and present therapeutic concepts involved in child abuse and neglect.

And Yet,

It only takes one physician in a community to exhibit concern and commit himself or herself to seeing that change does occur.

The pediatric specialist in child abuse and neglect must be salaried, at least on a part-time basis. This salary can come from a variety of sources a large group practice, medical school, neighborhood health center and Department of Social Services are examples. There is *no way* that we can expect the private pediatrician, working on a fee-for-service basis, to become a specialist in child abuse and neglect unless he or she has an independent source of wealth. This should not be taken to mean that other physicians are not involved, rather that help and consultation are available when they need it. This is very much like any other serious problem confronting the physician in his practice.

The child protection team of which our pediatric specialist is a member would include a community protective service worker, public health nurse, pediatric specialist, psychologist, hospital social worker, lawyer and, occasionally, a law enforcement person. This concept is discussed in some detail in a new OCD manual. *

What Can Be Done Now

"All this is well and good," said a social worker from a local community with whom I discussed these proposals, "but we need doctors now." I agreed that waiting for curriculum revision in medical schools and residency training programs cannot solve a community's problems. Instead I suggested, "Stop looking for *doctors* to solve your problem and seek out one *doctor* or maybe two in your community." Once a single physician (usually a pediatrician or family practitioner) is identified as having even a slight interest in this area, you are beginning to make progress. You may then proceed as follows:

1) Arrange for this doctor to see a patient or two in consultation.

2) Ask him or her to attend a conference about the family. This conference should be well organized and no more than an hour in length.

3) Subtly increase the physician's involvement until you have him or her "hooked."

At this point a priority problem will develop. If the doctor is in practice, his private office patients will begin to be neglected and a serious financial problem will occur. If he or she is salaried, then the boss will begin to complain about time commitments. Communities have faced these issues in a variety of ways, but some funds (relatively a small amount at the outset) will be necessary as a token of their appreciation. Pooling the limited financial resources of several groups and agencies will help.

Eventually, one or two pediatric specialists in child abuse must be an integral part of *every* Protective Services program in the country.

In summary, by providing early child development specialists in pediatrics and/or family medicine to deal directly with the problem of child abuse and neglect—and by providing these specialists with a salary—we will have available the kind of consultants who can make the specialty of child abuse and neglect a legitimate enterprise.

There are very good reasons why physicians are reluctant to become involved in the problem of child abuse and/or neglect. These reasons are real and well embedded in our system. And this situation must be changed. Modifications in our undergraduate and graduate educational programs, the training of pediatric specialists in child abuse and neglect and the subsidizing of these specialists to make them part of a community and/or hospital-based child protection team will move us a long way toward overcoming the problem of minimal involvement on the part of physicians. ■

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* *Child Abuse and Neglect: The Diagnostic Process and Treatment Programs* by Ray E. Helfer, M.D., Office of Child Development (In Press).

understanding and helping child-abusing parents

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Owen L. Caskey
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The problem of child abuse has been described by Kempe (1969) as a disease of epidemic proportions in the United States. This problem can be divided into three broad and complex areas that span legal, medical, and social fields: casefinding, immediate treatment and protection of the child, and treatment of the abusing adult to improve the home situation to enable a child to return to it and grow safely within it. This article will discuss factors relevant to the last point.

The definition of child abuse varies in state laws pertaining to it. Some states include starvation, malnutrition, sexual abuse, and failure to thrive in the definition; other states use broad language such as "serious physical injury" or "injuries inflicted upon him other than by accidental means." The Colorado law, for example, states specifically that:

> Abuse means any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, sexual molestation, burns, fracture of any bone, subdural hematoma, soft tissue swelling, failure to thrive, or death, and such condition or death is not justifiably explained, or where the history given concerning such condition or death may not be the product of an accidental occurrence. (De Francis 1970, p. 113)

Arizona, on the other hand, recently broadened "abuse" to mean

> . . . the infliction of physical or mental injury or the causing of deterioration of a child and shall include failing to maintain reasonable care and treatment or exploiting or overworking a child to such an extent that his health, morals, or emotional well-being is endangered. (De Francis 1970, p. 114)

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The recently enacted 1974 Texas Family Code was intended to represent a broadened redefinition of abuse, with the mandate to report violation of compulsory school attendance laws on three or more occasions.

In a symposium on the problem of child abuse conducted by the American Academy of Pediatrics in 1962, Kempe directed attention to the seriousness of the problem by proposing the term "the battered child syndrome." In a period of six years, the term received national attention and, along with publication of national surveys of child abuse, generated such great interest in the problem that reporting laws in all 50 states were passed with regard to child abuse. Since that time, Kempe is of the opinion that the term "battered child" has achieved its purpose and that the term describes only a narrow part of the syndrome and tends to be prejudicial. For this reason, he now believes that the terms "nonaccidental injury," "abuse," or "failure to give reasonable care and protection" are preferable to the earlier terms (Kempe & Helfer 1972). For whatever reason, it appears the "abused child" has been the term most frequently found in the professional and popular literature since the early 1970s.

Extent of Child Abuse

Despite attempts to identify child abuse cases, there are no accurate national statistics on the incidence of child abuse. The authority most often cited is Gil's (1970) compilation of the number of physically abused children during 1967 and 1968; yet he cautions extrapolation of his findings beyond the tabulation of reported abuses and deaths, which numbered 5,993 and 6,617 for the reporting years. Other writers, even in professional journals, make general estimates without citation or cite newspaper articles as sources of the extent of child abuse. These estimates range from 10,000 to 500,000 cases of child abuse annually. The 10,000 cases reported in 1969 by the American Humane Society probably represents the most conservative estimate, the 50,000 annual incidence estimate of the U.S. Children's Bureau a modest appraisal, and perhaps 200,000 children annually in need of protective services of which 30,000 may be badly injured may not be unrealistic (Solomon 1973). Incidence of child abuse does not lend itself to standard sampling techniques, nor does the compilation approach using official reports of the states (over 20,000 in 1972) describe the extent of the problem. Add to this the definitional difficulty (what constitutes "abuse"?) and the natural reluctance to report suspected cases, and the logical extension of reported cases of child abuse by severalfold becomes a most reasonable estimate.

Child Abuse Legislation

After decades of concern for punishing those who would abuse a child, but little in the way of preventive legislation, national interest was focused on the need for reporting laws, first by the 1962 study of the Children's Division of the American Humane Association tabulating severe abuse incidents, and later by the extensive studies of the quality and quantity of the abuse of children in the United States conducted from 1965 through 1968 by the Children's Bureau of the Department of Health, Education and Welfare. During the four-year period from 1963, when the first law was passed, until 1967, state legislatures in all 50 states passed child abuse reporting statutes. Initially, these statutes were directed toward encouraging reports from the medical profession, but later statutes and amendments established a trend toward broadening the base for reporting and identifying child abuse cases for appropriate response, both punitive and protective.

Mandatory rather than permissive reporting is generally required, with only two state statutes (North Carolina and Washington) avoiding mandatory statements by 1974 and with at least 25 providing criminal penalties for failure to report. Although there is some doubt that these provisions are rigorously enforced, they are intended more to give the prospective reporter added motivation. Those required to report suspected child abuse most frequently include those in the medical profession (47 states). Following, in order, are social workers (22 states), teachers (16 states), school authorities (13 states), and an all inclusive "any person" category (3 states). There is some overlap in the teacher-school authority reporting groups, but some states do separate the categories. California, for example, requires school administrators, but not teachers, to report suspected cases of child abuse. As of the early 1970s, a total of 28 states required someone in the school system to report suspected incidents, if one includes the three "any person" states.

De Francis (1970b) points to a trend in legislation during the past few years moving in the direction of designating a central agency (the welfare agency is cited by 34 states) to receive and act upon child abuse reports and the creation of a central registry to aid in the identification of reported abuses. By 1970, 45 states maintained a register by either legislative mandate or administrative order. All states except Colorado grant immunity to persons required by law to report, although some states limit such immunity to situations involving civil liability. Finally, 39 states have provisions releasing reporters from privileged communication restrictions which may be imposed by professional codes of ethics, or, in some cases, by conflicting practitioner-client and husband-wife privilege statutes.

Abusive Parents

Characteristics

Violent behavior by a parent toward a child was once regarded as the result of hardships produced by immigration, war, poverty, ignorance, or industrialization. It has since been pointed out that such behavior is not exclusive to any particular class or cause. A sociological explanation by itself is inadequate, and child abuse is not directly related to race, color, creed, sex, income, or education (Wasserman 1967). Kempe (1969) believes that child abusing behavior may be intensified by poverty, overcrowding, or unemployment or modified by the number of doors that can be closed in the home between the injured child and the parent, but that its deeper cause is psychodynamically determined. It would appear that, regardless of social class, abusive parents have certain psychological and social characteristics in common, but may, in fact, be loving of their children.

The purpose of this review is to direct attention to this group. It has been estimated that 90 percent of abused children can remain with their parents, occasionally with a brief period of separation during an acute episode, provided adequate treatment is planned and implemented for them. In the remaining 10 percent of the cases, permanent separation will need to be requested following psychiatric examinations (Kempe 1969).

In looking at some of the characteristics of the large majority of abusing parents, Wasserman (1967) states that we are dealing with a group of lonely and isolated people, although this may not be observable in beginning contacts. Few, he says, are psychotic, but all have a marked inability to set up a genuine relationship with another human being. They are so absorbed by their own hurt feelings that they cannot really sympathize with the feelings of others. Being greatly in need of receiving, they themselves cannot give. Reiner and Kaufman (1969) say this kind of person is unaware that he has a buried feeling of "embedded depression" because he was emotionally or psychologically abandoned by his parent as a child, an act the individual interpreted as rejection of himself. Failing to understand the distressing rejection and not being strong enough to bear it, the person has buried the feeling of rejection and accompanying depression. Explosive, violent behavior becomes a method of numbing the deep hurt or sense of worthlessness. The pattern of aggression and violence is learned, causing the person to inflict on others that which was inflicted on him. Glass (1970) offers support for this belief in his observation that battering parents are adults who were not loved as children and may have been abused themselves, either physically or emotionally, by their own parents.

Steele and Pollock (1968) searched for a consistent behavior pattern which might exist in combination with (but quite independently of) other psychological disorders in parents who abuse children. Abusive parents expected and demanded a great deal from their children. Their demand for performance was frequently beyond the ability of the child to perform or even to comprehend what was expected of him. It was concluded that the parent feels insecure and unsure of being loved and is actually looking to the child as a source of reassurance, comfort, and loving response. It is a case of the parent acting like a frightened, unloved child and looking to his own child as if the child were an adult capable of providing needed comfort and love. Abusive parents seem to believe that children's needs are unimportant and should be disregarded. To the child abuser, children exist primarily to satisfy parental needs and those who do not fulfill these requirements deserve punishment.

In the background and life histories of the parents in the Steele and Pollock study (1968), the researchers found that all had experienced intense parental demands for submissive behavior and prompt obedience accompanied by constant parental criticism. Inevitably, the children felt unloved and that their own needs and desires were disregarded or even wrong. Steele and Pollock found that this pattern of parent-child relationship or style of childrearing is transmitted from parent to child, generation after generation and is, to a large extent, probably culture bound. Josselyn

(1956) observed that motherliness is not a prerogative of women alone; it is a human characteristic and is seen as the ability to show tenderness, gentleness, and empathy and to value a love object more than the self. With adequate "mothering," the human being develops a sense of confidence. Abusing adults did not have this confidence-producing experience. They may have a maternal "image" intact and may continue to return to their parents seeking from them some evidence of love, but they usually find the more familiar criticism. Abusing parents feel that it is unrewarding to look to family, friends, or others for need-satisfying relationships. The abusing families tend to lead a life which is alienated, asocial, or isolated. The pattern of lack of confidence engendered early in their childhood with their parents persists. The relationships they describe are meager, superficial, or authority based (Steele & Pollock 1968).

In child abuse incidents, not only a seriously disturbed person is involved but also a disturbed family. Lack of confidence plagues the marriage of the abusing adult. Despite the presence of admirable qualities and abilities, the spouse of the abusing adult is often dependent, unable to express needs clearly, and, at the same time, demanding, critical, and unheeding. Like many neurotic people, abusing adults have usually become involved with someone much like themselves or their parents. Solomon (1973) summarizes the parents, as reported by state central registries, as married, living together, and in their late 20s or early 30s. Helfer (1970) believes that a long unmet need for love motivates the abusing adult to turn to the child in hope of having these needs met. The parent becomes the one in need of receiving mothering. Helfer states that mothering, the ability to accept help from others, and the ability to provide help to others are all learned functions, and, since abusing adults received little emotional support from their parents, they have not learned to establish mature emotional relationships. As a result of the inability to establish mature emotional relationships, they literally do not know how to give to or accept from others. Further, they have usually sought marriage in a desperate attempt to fulfill some of their needs, but have often found spouses who are unable to supply the help and support they need. If a baby is born into this setting, the parents may actually expect the child to meet needs which have not been met most of their lives.

There still exist contradictory conclusions regarding the role of family characteristics. Gillis (1973) quarrels with the current research which explains child abuse as a function of psychological pathology and instead suggests a multidimensional approach focusing on the sociological and contextual variables associated with abusive parents. Light (1973) holds out little hope that studies will produce a social profile of abusing and nonabusing families which will discriminate adequately between the two groups for purposes of early detection and prevention. Further, he concludes that child development education programs have not been shown to affect problems of child abuse. His recommendations include the need for more family planning education and more careful investigation of reporting systems from which better treatment programs can be devised.

Relating Treatment to Needs

Helfer (1970) maintains that the treatment goal should be to meet the needs of the abusing adult in order to lower the adult's expectations of the child. Kempe (1969) states that the therapeutic goal should be to enable the abusing adult to let go of the child as a source of satisfactions and transfer his needs to someone else. The therapy described by Steele and Pollock (1968) with their study group is a type of reality-based treatment, the goal of which was to provide whatever treatment was necessary in order to make the home safe for the child. In his early papers on child abuse, Kempe (1969) recommended treatment which he called "relationship therapy." In practice this became so demanding on the professional staff that lay workers were introduced into the program at the Colorado General Hospital to meet the increasing caseload. Kempe and Helfer (1972) recommend training of lay workers and use the term "mothering therapy" to describe treatment for the abusing adult. Experiences with introducing a "mothering person" into the situation indicate strongly that this person, whether a professional or a paraprofessional, must be available to the abusing family most of the time and for very long periods. Clearman (1970) and Davoren (1968) see the process as establishing trust and displacing the abusing adult's dependency needs. It is questionable, however, whether an adequate number of lay persons with the skills necessary to function in this role will be any more available to schools and agencies than will professional counselors and social workers.

Working with Abusive Parents

Based on the evidence of the characteristics of child-abusing adults, the following needs should be considered with regard to selecting treatment resources: need for improved social and personal relationships, need for limits and reality learning, and need for both parents to be involved in treatment. A change only in the child-abusing adult may add additional stress to an already stressful home situation, and it is possible that it may lead to abusive behavior in the other parent. Elementary school counselors, school social workers, and school psychologists can aid many abusive parents by including them in ongoing or special groups while at the same time providing counseling and other services for the abused child.

Group Processes

There is some indication that group methods of treatment are desirable, perhaps even preferable, in the treatment of many abusive parents, who may find individual counseling too threatening and anxiety provoking. Such parents have been described as typically unskilled; they tend to deny their difficulties, have problems controlling impulses, and experience difficulties with authority. All of these problems have responded to appropriate application of group techniques. Group work with abusive parents uses group processes to make constructive psychological changes, such as the reduction of anxiety or an increase in self-confidence in individuals in a group setting. The goal in such groups is to effect personal growth and social adjustment and is parallel to the goal for abusive adults seen in individual counseling. The values and objectives of group activities, which help parents gain a fuller realization and acceptance of themselves, look more carefully at their feelings and activities as they interact with others, and learn to alter behavior and attitudes in order to be accepted by the group, seem well-suited to working with abusive parents. Group counseling also has the advantage of providing a firsthand experience when interaction with others occurs, and, in general, such experiences are likely to be much more effective in producing self-concept and behavioral change than are the more symbolic experiences.

Reiner and Kaufman (1969) hold that a group experience has special meaning to persons with character disorders, since, as a result of their fear of close relationships, they experience great loneliness. Since persons become psychologically ill and unhappy in social groups, the premise that they can re-establish their emotional equilibrium in productive human relationships through social interaction is a logical approach and may well be essential for personality change and growth. Such an experience may occur in a group situation where conditions are favorable for gaining new glimpses of one's relationships with others. Reiner and Kaufman report working with several character-disordered mothers who met once a month in a group setting. They observed that the mothers showed a noticeable growth in the handling of their children, and the gains seemed to carry over to other situations.

So-called nontherapeutic groups, such as problem-solving groups, may have therapeutic consequences. Zalba (1966) reports that the Jefferson County Welfare Department in Louisville, Kentucky formed a heterogeneous group of parents of abused and neglected children. The meetings were to supplement and reinforce efforts to help these parents meet others with similar problems, to have a social experience, and to learn about discipline, normal child growth, parent-child relationships, and husband-wife relationships. In the process, group spirit developed, personal problems were discussed, and participants developed in personal and social ways. Most significantly, there was attitudinal change with regard to children as well as improvement in family and marital relationships.

School-Centered Approaches

The bulk of the literature on helping abusive parents centers on the 10 percent who severely injure their children and need highly specific and long-term treatment, just as the professional reports (particularly those in law and medicine) of abused children cite those who are marked by serious physical and emotional scars which will remain for years, even with the best of care. If the conclusion that the greater majority of abusing parents are amenable to help other than psychiatric or clinical therapy programs is tenable, then counselors, social workers, and psychologists working within the typical school setting have a role in providing assistance to these parents.

In a most general way, this would at least include acquiring knowledge about the problem of abused children and abusive parents, with specific information which is relevant for the legal, ethical, and professional responsibility as it relates to the locale in which they work. Welfare agencies, medical associations, and bar associations at both local and state levels can provide inservice programs to acquaint school special service workers, as well as instructional and administrative personnel, with current directives, responsibilities, reporting channels, and treatment programs.

A second step would be to inaugurate programs which would attempt to involve parents who were suspected of abusive actions in programs which might be of help to them and aid both their children and the family situation. Special encouragement is necessary to involve such parents in child study groups, parent education, or adult education programs, but any activity which can help improve personal-social relationships and understanding would be directly related to areas which have been identified as crucial for abusing parents. When identification of parents with abusive tendencies produces sufficient numbers, special groups or programs for parents or family groups could be attempted following the guidelines used for working with any parent groups, regardless of the problem area. If the typical pattern of loneliness, isolation, and unmet needs exists, getting parents to participate in these activities may not prove to be the problem it appears to be on first contemplating how these parents can be brought together for help.

A third step would be to devise programs designed to serve in identification or treatment of abusive parents or their children in a more direct way. The Adams County (Colorado) project is an example of a county-wide effort using the school as the focal point (Nordstrom 1974). Every school employee is charged with the legal responsibility to report suspected child abuse incidents or see that a report is made. Reports are processed by a task force including a psychologist, a counselor, a social worker, a nurse, and an administrator. During 1972–73, 24 cases were processed by the team, reported to the Welfare Department, and included in a central registry. It is pointed out that the important factor here is the willingness of a school system to reevaluate its responsibility concerning child abuse and develop coordinating efforts with community resources to report cases of child abuse.

Although programs of direct service are more difficult, some larger schools may have the capability to move in this direction.

The adaptation of relationship theory, which proved effective with abusive parents but was too demanding of counselor and social worker time, might be a productive role for counselor aides and guidance associates. Through training, these individuals could develop the understanding and techniques which would allow them to work closely with the families of abused children, perhaps to the extent of becoming a significant and available surrogate member of the family.

Encouraging teachers to become more aware of children who may be abused, or alert to indications which might cause them to suspect child abuse cases, can create detrimental effects unless it is a part of an organized program. Teachers who may take it on themselves to talk to parents or make random charges or informal reports could create additional difficulty for the child in his home situation. As a result of a national survey of schools enrolling over 10,000 students, Drews (1972) compiled suggestions for an organized reporting system based on questionnaires returned by school systems who were concerned about problems of child abuse. The most important factor identified was to develop an organized system of processing information concerning suspected abused children. This system would include a special training program for all school staff members, specific instructions for reporting, referral procedures to ensure that the child was seen by the school physician, a process to communicate information to the appropriate agency, and a system of follow-up to determine the disposition of the referral for both the cooperating agency and those concerned with the child and the family. Although the details and application of this sequence would differ with school districts and cooperating agencies, the recommendation to have an organized program which provides something more than an awareness of the problem of abusive parents would seem to be a minimal requirement for any school system planning programs in this area.

Counselors should be aware of the existence of programs which may operate on a state or local level and are designed specifically to help in cases of abuse. Perhaps the best example of such an organization is the Service for Child Abuse and Neglect (SCAN), which is currently establishing chapters in a number of states. This program provides referral procedures, therapy for families and individuals, day-care facilities, and parent group activities and sponsors a "parents anonymous" program patterned after the Alcoholics Anonymous programs. SCAN operates a national center from which additional information can be obtained[1] and could aid in establishing local and state programs.

Finally, it would seem that, given the concern and interest in seeking ways to be of help to parents suspected of abusive tendencies, any number of ways could be found to adapt the activities and programs available to school systems to focus on this problem. Counselors could offer to accompany teachers on routine home visits, sit in on parent-teacher conferences, arrange for programs to parent groups, help develop special volunteer programs, or convert regular or special school-home interaction to meet objectives of offering help to potential abusive parents. With little in the professional literature in the way of program suggestions or reports and only isolated research concerning experimental or controlled projects designed to deal with abusive parents, schools must rely on the concerns and talents of interested staff members. Elementary counselors have both the skills and opportunity to make valuable contributions and exert leadership in this important area.

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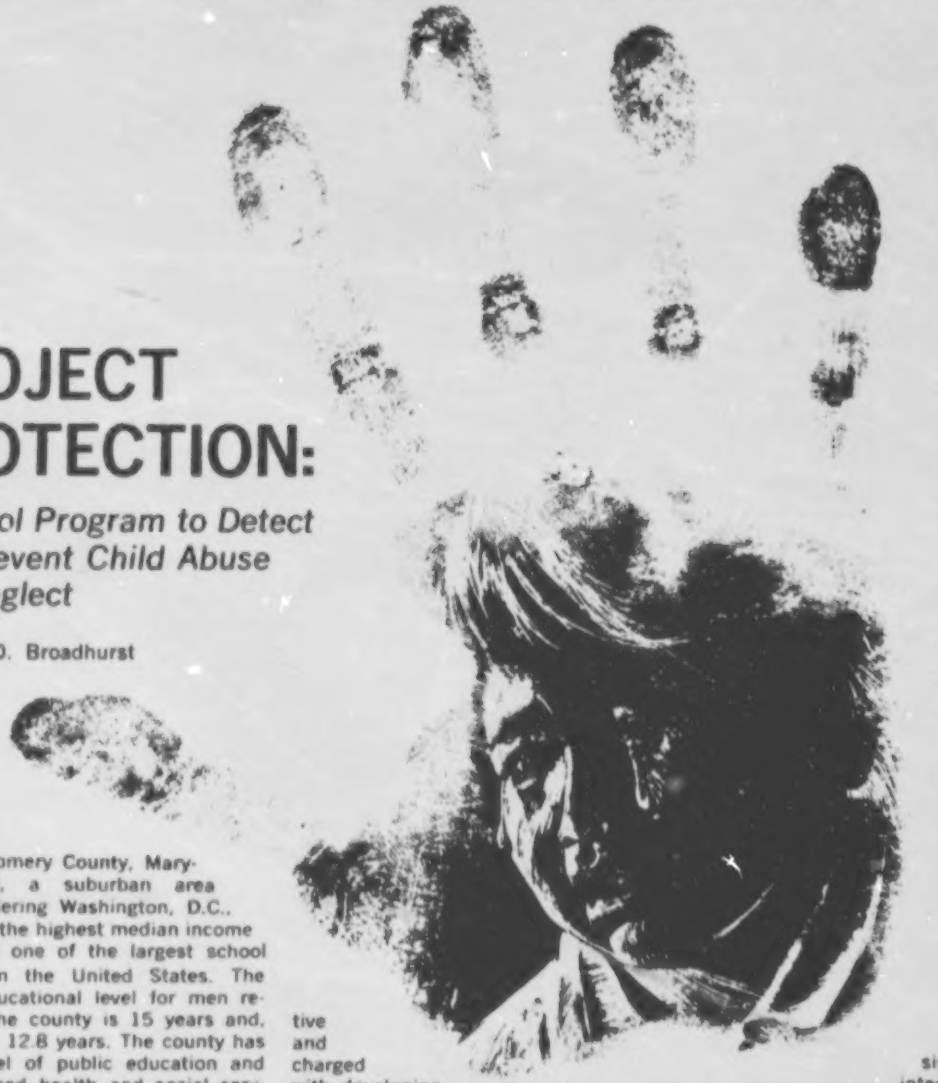
[1] National Center for the Protection and Treatment of Child Abuse and Neglect, SCAN Program, University of Colorado Medical Center, 1001 Jasmine Street, Denver, Colorado 80720.

PROJECT PROTECTION:

A School Program to Detect and Prevent Child Abuse and Neglect

by Diane D. Broadhurst



Montgomery County, Maryland, a suburban area bordering Washington, D.C., has one of the highest median income levels, and one of the largest school districts, in the United States. The median educational level for men residing in the county is 15 years and, for women, 12.8 years. The county has a high level of public education and well-developed health and social services. It also has abused and neglected children.

The brutal death in 1972 of a 9-year-old Montgomery County girl, and the indictments for murder of her father and stepmother, shocked residents and was the catalyst for an intensive effort to alert the public to the phenomenon of child abuse and neglect and to improve county policies and procedures for reporting and handling abuse and neglect cases.

Later that year a Task Force on Child Abuse—composed of members from county health, social services and law enforcement agencies, the school system and the public sector—was appointed by the County Executive and charged with developing specific programs and recommendations to improve services to abused and neglected children and their families. Under a comprehensive community plan developed by the Task Force, the position of child protection coordinator was established within the Office of Human Resources, health and social services staff were increased to extend coverage for receiving and investigating reports, and a multidisciplinary child protection team was formed to evaluate cases and develop service plans for them.

The Montgomery County Public Schools' Project PROTECTION, initiated in August 1974 with federal assistance, is an integral part of the county's efforts to combat child abuse and neglect. It is one of three projects funded by the U.S. Office of Education under Title III of the Elementary and Secondary Education Act to train teachers to recognize and properly refer children suspected of being abused or neglected.

Concern for the school-age child is long overdue. In testimony before the Senate Subcommittee on Children and Youth in 1973, David Gil stated that about half of the reported abuse incidents involved school-age children. In Montgomery County the median age of the abused child is nine—and about 75 percent of reported cases involve

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school-age children.[1]

Few school systems have recognized the challenge implicit in Dr. Gil's findings; fewer still have acted. The schools, however, are in a unique position to identify and to help abused and neglected children and their families. In school, a child's appearance and behavior are observed regularly by a number of people—among them the classroom teacher, school nurse, guidance counselor and principal. If these people are trained to recognize the characteristics of abuse and neglect and know how to report their suspicions to the proper authorities, they can make an important contribution to community efforts to combat child abuse and neglect.

Montgomery County's 135,000 school-age children attend 202 public and 60 nonpublic schools, where they are seen regularly by more than 7,000 teachers. A major objective of Project PROTECTION, as its name implies, is to afford maximum protection to these children by assuring that all school staff members are trained to recognize child abuse and neglect, are aware of their obligations to report it, and know the procedures for doing so. We are also working toward prevention of the phenomenon by developing curriculum units which will help teach future parents how to better understand and handle their own children.

Project PROTECTION involves three phases: policy revision, staff development and curriculum development. Under the first of these, the school district's Policy Statement on Child Abuse and Child Neglect, first adopted in 1973, was revised and adopted by the school board. The new statement requires that all school employees—including classroom teachers, principals, school health nurses and health aides, speech clinicians, guidance counselors, psychologists and social workers—refer to proper authorities all children whom they suspect may be abused or neglected. This provision conforms with 1974 amendments to the Maryland child abuse statute.

The policy statement defines an abused child as any child under age 18 who "a) has sustained physical injury as a result of cruel or inhumane treatment or as a result of malicious acts by his parent or any other person responsible for his care or supervision; b) has been sexually molested or exploited, whether or not he has sustained physical injury, by his parent or any other person responsible for his care or supervision." The statement points out that an employee does not necessarily have to observe any external physical signs of injury to the child to report. "It is sufficient merely to presume that abuse has occurred when a child complains of having been sexually molested or of pain, which he says has resulted from an inflicted injury. In such cases, the report should be made."

According to state guidelines, a neglected child may be malnourished, ill-clad and dirty; unattended; ill and lacking essential medical care; exploited and overworked; emotionally disturbed due to friction in the home; neglected emotionally by being denied "normal experiences that produce feelings of being loved"; and exposed to unwholesome and demoralizing circumstances.

The statement emphasizes that any doubt about reporting a suspected situation should be resolved in favor of the child.

One of the few such school policies in the nation, it also describes the procedures for reporting, explains that immunity from any civil or criminal liability is granted, and includes a sample of the county child abuse and neglect reporting form. Copies of the statement were sent to every school staff member and distributed widely in the community and to other school systems.

Developing a system-wide policy is an excellent first step for any school system to take to focus on child abuse and neglect. Such a policy should be designed for a system's particular needs and laws and then adopted by the school board. Once a school system has determined what it can and will do about child abuse and neglect, program design can follow naturally.

Staff Development

Staff development, the largest phase of the project, was conducted on three levels and across several disciplines. At the beginning of the current school year, a one-day conference was held to discuss the early identification of high-risk children and to explain the Maryland child abuse statute and county policies and procedures to all public school administrative and supervisory staff. About 500 people, including representatives from county health and social service agencies, nonpublic schools and neighboring school districts, attended.

Immediately following that conference, school pupil services staff—psychologists, social workers, pupil personnel workers and counselors—attended an intensive 2-day training workshop designed to prepare them to conduct staff development programs in individual schools.

Techniques for identifying abused and neglected children were described, the county supervisor of protective services explained what happens after a report is made and the county child abuse coordinator discussed the work of the county Child Protection Team. Other discussions focused on the psychodynamics of abusing and neglecting families, working with abused and neglected children and their families and sexual abuse of children.

Representatives from county departments, nonpublic schools and neighboring school districts also attended the workshop, and all 125 participants received a detailed information packet and a bibliography of the child abuse materials available in the school system's professional library.

In the third phase of staff development, members of pupil services staff conducted training programs during regularly scheduled faculty meetings in all public schools in the county. A model presentation was designed and adapted to fit the needs of the school served, for the purposes of helping staff members recognize child abuse and neglect; making them aware of their responsibility to report and the immunities provided; and informing them of the proper referral procedures.

Staff members described "indicators" which could alert teachers to the possibility of abuse or neglect of children in their classrooms. These include, for example:

- Unexplained injuries, or discrepancies between the explanation given and the degree of injury observed.
- Repeated or bizarre injuries, including cigarette burns and strap or rope marks.
- The odor of alcohol on a child.
- A child whose height or weight is three to four standard deviations be-

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low the norm for his age.

- A child who is afraid of his parents, or parents who show little or no concern about the child and his welfare.

Health and supporting services staff and executive committees of PTA and student government organizations were invited to attend. Project staff have also conducted information programs for high school and college classes and for PTAs and service groups.

Training programs have reached thousands of Montgomery County citizens—and the county has had a steady rise in the number of suspected cases reported.[8] More important, however, are the heightened awareness of child abuse and neglect problems in the schools and community and the steps being taken to help children and their families, as the following examples illustrate.

Alan Grey, a junior high special education student, was referred to Protective Service by his gym teacher who had noticed heavy bruising and cuts on the boy's back.

Alan readily admitted that his stepfather had beaten him with a belt buckle the night before, but added that he had deserved the beating. When questioned, Alan was extremely protective of his parents, saying that it was all right for them to beat him because he was "born bad." He expressed the fear that he would be placed in a foster home, something he had experienced several years before in another state.

Investigation revealed that Mr. Grey, a heavy drinker, had a history of violence. Mrs. Grey, an extremely passive woman, never interfered with her husband's disciplining of Alan. The family was known to social agencies wherever they had lived.

Because of its complexity, the case was referred to the County Child Protection Team. Although many of the agencies represented on the team already knew the Greys, none had been able to establish a successful relationship with them. The Greys were extremely resistant to help from anyone and had often expressed their distrust of professionals—with the single exception of Alan's special education teacher, whom the Greys seemed to like and respect.

Because Alan was already beset with emotional and behavioral problems and fearful of foster care, foster placement did not seem to be the answer. A better solution, the team felt, was to keep Alan at home and in his regular school where he already had a good relationship with his teacher. It was further made clear to the Greys that they had to see that Alan was properly cared for. They were encouraged to let Alan join some after-school activities.

Alan's teacher and his school were willing to work with the Greys. Frequent conferences were scheduled between the Greys and Alan's teacher, the school's social worker or psychologist. The school subsequently arranged for home visits by the social worker.

The situation is considered far from stable, and the case is carried as an active one by Protective Service. The Greys frequently talk of moving to another state; meanwhile, the school keeps a close eye on Alan, and the Child Protection Team receives routine reports on the Greys' progress.

In another case, Jimmy Brown was referred to Protective Service by his third grade teacher who noticed crisscross black and blue marks on his face, apparently caused by a hard object of some kind.

Subsequently, investigations revealed Jimmy's bruises had been caused by his mother striking him with a heavy stick. Mrs. Brown explained that she always used a stick to discipline Jimmy, who was a "bad boy" and "needed it." Mrs. Brown said that she usually struck Jimmy on the back or buttocks, and that it was his own fault he had been struck on the face. She had told him to stand still, as she usually did, but this time he ducked, and the stick caught him across the face.

Both Mr. and Mrs. Brown were isolated people who expected too much of Jimmy. Neither would agree to any kind of family counseling or outside help; they said they preferred to solve their problems on their own, through meditation. Conversely, they were willing to learn more about alternative means of disciplining Jimmy, and it was possible to get them to join a parent education program at the local school.

A social worker continues to visit the Browns, and there is some hope that they will agree to family counseling after the parent education course concludes. There has been no further injury to Jimmy, but the situation continues to be monitored.

Of course, investigations may reveal that abuse did not in fact occur, as in the case of Ann Green. The investigation initiated by the report, however, has led to needed help for the Greens.

Seven-year-old Ann came to school one morning with a large, ugly bruise on her cheek, which she said had been caused by a blow from her father. Ann and her 9-year-old sister were new to their school. Thin, pale children, they were frequently absent and always shy and withdrawn. Although Ann was hazy about the injury and her story contained elements of fantasy, Ann's teacher still felt there was reason to file a report of suspected child abuse or neglect.

Investigators learned that the Green girls lived alone with their father in a rural home. Despondent over the accidental death of his wife the preceding year, Mr. Green, a college graduate, had left the profession for which he was trained and had moved to a new area to raise livestock. He worked long hours, and the girls were frequently left alone for extended periods of time. There were no near neighbors, no playmates and few visitors.

The investigation determined that Ann's injury had been the result of a fall, a fact corroborated by her sister. Mr. Green was cooperative with the social worker assigned to the case and clearly demonstrated his concern for the girls. He said he realized it was not good for them to be so isolated, but he could not seem to take an interest in anything. He had not known of Ann's injury. Both girls had been asleep when he returned the night before, and he had left the house that morning before either was awake.

Mr. Green readily agreed to work with the school to see that the girls attended more regularly, and he became involved in school activities. He also arranged after-school care for the girls.

Staff development activities also include cooperating with the school system's Department of Research to conduct a series of structured interviews with school, social service and law enforcement personnel who have worked with actual cases. The data gathered from these interviews will form the basis for developing guidelines and manuals.

About 15 percent of the school-age children in Montgomery County attend nonpublic schools. To reach this group, Project PROTECTION distributed information on child abuse and neglect to each school, and staff development programs have been conducted in many of them. In cooperation with Project PROTECTION, a social work field unit from Catholic University of America provides direct service, focusing on early detection and prevention, in nine nonpublic schools.

Traditionally, Montgomery County's nonpublic schools have reported few cases of suspected child abuse and neglect. Their attitude has been that abuse and neglect do not occur among their selected population. One principal told project staff, "This program does not apply to us. We are an affluent school. Our pupils are carefully screened." But the conditions that give rise to abuse and neglect may have little or no relation to a family's educational preferences or income. Reports, for example, have come from public, parochial and private schools; from upper- and lower-income neighborhoods, and from rural and urban communities within the county. Obviously, abused and neglected children may be found in *any* school. It's merely a question of recognition.

Curriculum Development

Curriculum development addresses the subject of prevention. This phase of the project will apply information about the underlying causes of child abuse and neglect to teaching units designed to better prepare students for parenthood. Existing curricula will be expanded and new units developed around four basic themes:

- *Nurturing Growth and Development and the Maltreated Child.* Characteristics common among abusing or neglectful parents include a lack of nurturing in their own childhood and an ignorance of a child's normal developmental stages. These often result in unrealistic expectations for the child. New teaching units will emphasize the importance of nurturing and the "nurturing imprint" in infancy, and will give increased attention to acquainting future parents with the normal developmental stages of early childhood.
- *Violence in Society and the Maltreated Child.* The tendency of maltreated children to become abusing parents or to commit other antisocial acts is frequently cited. Thus, teaching units will address the relationships between violence in society and violence against children.
- *Stress in the Individual and the Maltreated Child.* Inability to cope with stress is often cited as one of the major factors contributing to the maltreatment of children. The importance of recognizing and coping with stress, whether it originates from within or outside the family structure, will be emphasized in this teaching unit.
- *Child Protection and the Maltreated Child.* In conjunction with the three areas of emphasis mentioned above, a teaching unit on child protection itself will be developed. This will include a history of child protection, a discussion of the maltreated child syndrome, and an introduction to community resources for the maltreated child and his family.

Students themselves have indicated that they want to learn more about the maltreatment of children. During the past year, for example, child development, human development, sociology and psychology students at many area high schools have chosen related aspects of child abuse and neglect for class projects. Many believe that a curriculum unit on "How to be a parent" should be required for all high school students. Although traditionally girls have been taught some parenting skills in home economics or other classes, they represent only 50 percent of the parent population. Courses on parenthood should be offered to all students and the courses should emphasize how important nurturing—or the lack of it—is to a child's normal growth and development.

Ultimately, the success of any school program in the area of child abuse depends upon those who are in daily contact with the children. If staff members are familiar with the maltreatment syndrome and can recognize the signals of a child at risk; if they know they must report suspected abuse and neglect, and that they have legal immunity when they do so; if they are familiar with required referral procedures; and if they are convinced that their referrals will be handled promptly and intelligently—they will become a vital force in the detection and prevention of child abuse and neglect.

Writing in *Helping the Battered Child and His Family,*[3] Kay Drews, former child abuse coordinator at the University of Colorado Medical Center, states:

"For the older child who is physically abused, his school may be his only recourse. And yet it is this very source of help that so often lets him flounder and return to his home day after day to be the victim of continued abuse.

"The school-aged child has been somewhat forgotten and pushed into the background in previous studies of child abuse. The strong emphasis has been on the battered *baby*—the child three years of age and under. The school can and should provide a resource for early case finding that would permit the development of a therapeutic family-oriented program. The major question is: If a child of school age is abused or subjected to incest, is the school system prepared and willing to provide help to the child and his family through an adequate and effective system of reporting?"

For Montgomery County Public Schools, the answer is "Yes!" ■

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[1] The significance of these statistics has not yet been fully explored. A child becomes more "visible" to more people when he or she begins to attend school and, at the time these statistics were reported in 1974, some school personnel had received training through Project PROTECTION to identify and report suspected cases. However, the large percentage of reports involving school-age children may indicate that private pediatricians, workers in day care centers and nursery schools and others who have regular contact with younger children are not fully aware of the problem and their obligation to report.

[2] Only 12 cases of suspected child abuse were reported in Montgomery County in 1971. In 1972, the year of the child abuse slaying, the number of reports rose to 53. They increased to 152 in 1973 and to over 200 in 1974.

[3] Kempe, C. Henry and Helfer, Ray E., editors, *Helping the Battered Child and His Family*, Philadelphia: J. B. Lippincott, 1972.

LOLA SANDERS, ROBERT W. KIBBY, SIDNEY CREAGHAN, and EVA TYRREL

Child Abuse: Detection and Prevention

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Most teachers, especially teachers of young children, hold fast to the principle of teaching the "whole child." Their conviction is no dreamy-eyed idealism. This principle corresponds to the physiological and psychological reality of human growth. The young child is a dependent of the total environment. When we speak of teaching the whole child, we express our commitment to relevant teaching. We relate our teaching to what the child brings to school: past experiences, relationships, the family's life style—the child's identity.

In order to meet this challenge of relevancy we, the teachers, have to become learners, conscious that our biases obstruct our learning process as effectively as a student's emotional problems may affect his or her performance. Acquainting ourselves with others' life styles, customs, and histories, we have learned that only through the awareness of our personal prejudices can we attempt to relinquish those prejudices. Not wishing to pay lip service to our philosophy of teaching the whole child, this process is never ending for us as teachers.

There is, however, one group of children who have often been excluded from our "learning approach to teaching." These are the battered children, physically and emotionally abused children. We realize that neither our willingness to help nor our skills in instructing reach the abused child. Our teaching is never relevant to his or her experiences. Always feeling endangered, the battered child may well be distrustful in all contact with the environment. When we are informed of the child's hostile home, we retreat before the parents in helpless anger or fear. We accept the label of "battering parents," which keeps us at a distance in this sensitive situation. However, "labeling a particular person as a 'battering parent' can release us from the responsibility of making our response to and attitude toward his actions sensitive to his needs. The temptation is great to think of him as being far removed from those of us who do not batter our children. In so thinking, we keep intact our image of ourselves as righteous," says Sidney Wasserman (1967).

In our school, we looked back on a history of problems of child neglect and child abuse. Confrontation with abusive parents did not improve the home situation of the most urgent cases. Parents often became hostile to the school and in some cases moved to another school district where the pattern of neglect was continued. The case of the S. children may serve as an example:

> When Kathy S. walked into the kindergarten room on the first day of school we thought her sister Mary had returned to us. The same fearful eyes met our eyes, the same glued-on smile pleaded, "Don't come close to me!" Kathy was the third child of the S. family registered at our school. Her mother had a history of drug addiction; her father was often absent from the home for long periods. Teen-age relatives and friends crowded the small house at all times. Mrs. S. had a habit of locking the children out of the house, not heeding their cries for food or use of the bathroom. The plight of the S. children was known in the neighborhood.
>
> When neighbors reported the situation to the Sheriff, Mrs. S. kept the children locked in a small room, out of her way. Our school reported their state of physical and emotional neglect, which retarded their school work and isolated them from other children. When the Sheriff placed Mrs. S. under his supervision, she gave some attention to their physical care for brief periods of time. Then, the children would again come to school dirty, sleepy, and hungry. Threatened with the removal of her children, Mrs. S. moved away, at a time when her husband was overseas on a job assignment.

The case of the S. children occurred some years ago, before we had learned of the work of the child protective services and their family rehabilitation program. The following case of Sandra R. will illustrate our successful collaboration with the social agency and their method of intervention.

> Mrs. R. enrolled her five- and six-year-old girls in our kindergarten. The older girl, Sandra, was a leukemia patient and had not attended school before. Mrs. R. lived

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with a friend who cared for the children while she worked. She also told us that Sandra would have to miss school every other Tuesday to visit the clinic for a blood transfusion and her check up. The household of Mrs. R. and her friend became known to the neighbors for heavy drinking and noisy parties. The children often talked about an uncle, a frequent visitor in the house. One morning the girls came to school very upset. This was their last day with us, they told us. The police had been at their house last night because their mother got hurt in a fight with the uncle. Now, mother no longer wanted them around. That afternoon, the girls were to fly to their grandparents. "And grandma doesn't want us either!", one of them said.

Because of Sandra's health, we felt obliged to check the veracity of the report. If Sandra left that day she would miss her appointment at the clinic the next day. Her health was seriously endangered. After discussing the situation with our screening committee, we called the child protective services. A CP worker immediately visited Mrs. R. and was successful in helping Mrs. R. reconsider her decision. The children remained with the mother and are still living in our district. The child protective services continues to work with this family.

Contacts such as the above with the child protective services made us aware of our ignorance of the legal, medical, and social dimensions of the child abuse problem. Why do parents turn against their own children with violence? Can we help prevent child battering? How do we recognize the child from an abusive environment? Can we report cases of suspected abuse? What are the most effective reporting methods?

The Magnitude of the Problem

When our county Department of Public Welfare sponsored two workshops on child abuse, several teachers, the school nurse, and a secretary represented our school. We hoped to learn answers to questions. Some grim statistics opened our eyes to the magnitude of the problem of child abuse:

> Child battering is a major killer of children today.
>
> If no family therapeutic program is initiated, the child, once released from a physician's care, stands a 25 percent to 50 percent risk of further permanent injury or death.
>
> Eighty-five percent of the children abused are under six years of age, 75 percent under four years of age, 25 percent under one year, and 16 percent under six months.

These estimates are conservative, as only a fraction of child abuse cases are reported to the authorities (Lenoski 1973). Contrary to the widespread opinion that the abusive parent is found most frequently in low-socioeconomic groups, it has been found that:

> Ninety percent of a group of parents reported are married and employed. They come from all walks of life, professions, ethnic groups. They are voters. Eighty percent confess to a religious belief. Only 10 percent are mentally ill. Only 8 percent are drinkers and only 2 percent are drug addicts. (Lenoski 1973)

Abusive parents most often repeat the pattern of their own deeply imprinted childhood experiences and learning. They may have no recollections of being loved, of feeling sheltered. They probably grew up with a deficient self-image and no feelings of self-esteem. They learned early to please their parents in order to escape severe punishments. Their own needs for love and attention were rarely met. Dr. C. Henry Kempe and his coworkers found some patterns of parent-child relationships characteristic of abusive parents, such as a high demand for performance and aggressive behavior toward the child when the demand is not met (Pollock and Steele 1968).

The child raised in such an environment usually develops self-protective, fearful behaviors. Such a child cannot turn to the parents for assurance. He or she is apprehensive. Abused children may dislike physical contact and may tend to isolate themselves from others. Mental development might be retarded, or speech may be slow in developing. Unless the child undergoes extensive treatment and is assured a protected period of growth, the abused child may become the abusive parent of tomorrow.

What Steps Are Being Taken?

Since 1967, all 50 states have enacted child abuse reporting laws. At present, the Institute of Judicial Administration in New York is revising the state's existing model Child Abuse and Neglect Reporting Law. "The revision of this model law, developed by the Children's Bureau in 1962, will be a major step forward in the department's efforts to combat child abuse and neglect," stated HEW Secretary Caspar W. Weinberger. The new model law will be offered to other states for use on a voluntary basis ("News & Reports" 1974). In California and many other states, all professionals, such as physicians, public welfare workers, teachers, ministers, etc., dealing with children, now can be found guilty of a misdemeanor if they fail to report an incident of suspected child abuse.

Once reported the child protective services must carry the burden of initiating the rehabilitation of abusing families. Their programs are undergoing profound changes to meet this complex challenge, and their workers are learning new skills for effective intervention in family interrelationships. Their new philosophy is based on

> a "reaching out" with social services to stabilize family life. It seeks to preserve the family unit by strengthening parental capacity and ability to provide good child care. Its special attention is focused on families where unresolved problems have produced visible signs of neglect or abuse and the home situation presents actual and potentially greater hazard to the physical or emotional well-being of children. (de Francis 1968, pp. 130-131)

When the agency receives a report of suspected or actual child abuse, the social worker calls on the parent. The worker's purpose is to convince the parent that s/he is there to help, not punish. Thus, the first genuine relationship the parent ever had may be initiated. This is the beginning of the therapeutic intervention. In order to help the slow process of rehabilitation and parental education, teachers must become acquainted with these methods of family intervention. Moreover, teachers may become instrumental in initiating the first contact between parent and social worker. "For the older child who is physically abused, his school may be his only recourse. And yet it is this very source of help that so often lets him flounder and return to his home day after day only to be the victim of continued abuse," writes Kay Drews in "The Child and His School" (1968). She asks: "If a child of school age is abused . . ., is the school system prepared and willing to provide help to the child and his family through an adequate and effective system of reporting?" (p. 115).

After lengthy discussions, our school principal decided to organize an inservice day for the study of child abuse. The objectives were two-fold: to gain information about the work of the social agencies, the police, and the court, and to learn techniques of detecting and reporting endangered children. A panel of public welfare workers, members of the Sheriff's Department, psychiatric social workers, and a district attorney shared their expertise with our teachers, administrators, school psychologists, school board and PTA members, parents of our students, and other interested citizens, including personnel from March Air Force Base. Pamphlets published by The American Humane Association were displayed and available on loan. Several copies of *Helping The Battered Child and His Family* by C. Henry Kempe, M.D., and Ray E. Helfer, M.D., were also exhibited. A folder of materials containing copies of the notes taken at the county workshops, along with "Guidelines For Schools," published by The American Humane Association, was provided for each participant.

The symposium was well received by citizens and school personnel. It served to alert the community to the child abuse problem and to suggest future steps which are now being taken. Teachers regretted the lack of time for discussion with panel members. However, the benefit of the symposium is lasting: To date, two cases of child abuse have been reported by teachers who had learned from the panelists to interpret characteristics of the abused child. In both cases the child protective workers have referred the parents for treatment.

Our school's task of helping endangered and abused children has only begun. Procedures have been set up for review of suspected abuse cases. If a teacher detects behavior syndromes of abuse in a student, the observations are checked with other teachers. The principal is informed of the findings and presented with other relevant data, such as attendance records or academic progress. The secretary, a key person in all parent and student contacts with the school office, also participates in these discussions which are of course kept confidential. If sufficient evidence of child abuse is determined, the child protective services are called. In most cases the teacher consents that the school is named by the child protective worker as referent. If marks of physical abuse, such as beating, are detected, the sheriff's office is called immediately.

Our collaboration with the child protective agency is still at an exploratory stage. All of us have much to learn in our contacts with emotionally handicapped parents and their children, as we become more skillful in working within the triad of family, school, and social agency. Often, the school is a place of refuge for the abused and neglected child. Extreme care must be taken not to destroy the child's relative security away from home by directing the parent's hostility toward the teacher and the school.

Reporting Child Abuse

The biggest barrier to aiding the abused child is the unwillingness of those who notice the child's distress to report the abuse. Reticence occurs from the understandable feeling that such reporting violates the privacy of the home; moreover, as Peggy Daly Pizzo and others note in their perceptive article "Child Abuse and Day Care" (1974), child abuse arouses both our rage at the parents and our fear that we are, at some point, capable of the same brutality. Neither attitude, however, helps the child.

Reporting abuse is the first step toward helping the child and the family.

> To *report* a suspected (you do not need proof) incident of child abuse or neglect telephone, in most states the local office of the Department of Child Welfare, part of the Department of Public Welfare. (Telephone their office and ask.) Usually, you will be required to give your home address and name, so investigators can contact you for more information if necessary. This information will be kept confidential, and no one will know that you made the report. An investigation of the family situation will be made. *Any* person can report child abuse or neglect and some states have made it illegal not to report when an incident is suspected. (Pizzo 1974, p. 3).

Certainly each school or child care center should ascertain the local procedures and give the information for reporting to every staff member. Workshops, such as the one described in this article, may be scheduled to increase staff sensitivity to and awareness of the problems of child abuse. Knowledge about child abuse increases the likelihood that the child's and parent's distress will receive intelligent attention.

The school also ought to inquire about agencies in the community that work with abusive or neglecting families. Some agencies are: The American Humane Association, Society for the Prevention of Cruelty to Children, Children's Protective Services, Children's Aid Societies, agencies specializing in family counseling, other social work and mental health agencies, the Visiting Nurse Association or other public health officials. In many states, parents with abusive tendencies have formed Parents' Anonymous groups which operate on principles similar to Alcoholics Anonymous groups. Parents intent on overcoming the problem of child abuse gain continued emotional support by their group meetings.

Perhaps Judge James J. Delany (1968) expresses our common concern best when he asserts that

> child abuse is predictable and preventable! Causes of child abuse can be detected and treated. Abused children can be protected. The abusive parent can be changed; the abusing and neglecting family strengthened; the child and his family reunited. We have only to care enough to act (p. 207).

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Stephen E. Forrer

Battered Children and Counselor Responsibility

In the United States at least 700 children die yearly from mistreatment and abuse by parents or guardians; thousands more are permanently injured either physically or mentally. There were approximately 60,000 reported cases of child abuse last year, with estimates of unrecorded incidents running into the millions. The American Academy of Pediatrics (1972) predicts an incidence rate of 250 suspected cases of child abuse per million population in urban areas. New York City reported approximately 2,700 suspected abuse cases in 1970, an incidence rate of 300 per million population.

For the school counselor, the implications of child abuse are very real. Although the probability of death or serious physical injury appears to decrease as the child increases in age, there remains a serious potential for psychological abuse of adolescents. Of equal importance, the counselor often must deal with behavior and adjustment problems resulting from an early history of abuse. The counselor's special training and abilities may be called to action in three general areas—counseling and working with parents, counseling and working with the abused, and participating in the community mental health response.

HELPING THE ABUSER

In dealing with the abusing parent, counselors should conceptualize the common antecedents of child battering. It has been suggested (Helfer & Kempe 1972) that for abuse to occur the parent must be predisposed, often as the result of his or her own personal history, to the use of violent child-rearing techniques and mechanisms. Evidence indicates that many child beaters have themselves suffered battering as a child and rely on these abusive interactions in dealing with their own children. The parent knows no alternative to violence or degradation.

Second, the abused child is often perceived by the parent as "different." This may be the child that fails to respond as expected or the one that is in fact special, reflecting retardation, a learning disability, or a physical handicap. The parental perception of this special child often elicits a response that is in itself different from normal reactions to children. Additionally, the perception of the different child allows

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the parent to psychologically detach normal values and mores from the child, thus permitting parental behavior that is not socially acceptable (Helfer & Kempe 1972).

Third, and most unpredictable, is the temporal ingredient of crisis. An externally caused emotional crisis, as a flat tire or headache, provides the necessary element of stress. The result is a parental reaction that is automatic, emotional, and for the predisposed parent, violent.

A recently successful method of helping the battering parent has been the formation of lay or professionally led therapy groups such as Parents or Families Anonymous. One important function of these groups is providing help during crisis situations by allowing a system of immediate access. A telephone call to a group member or therapist can often take the parent over the crisis. Rehabilitative groups may also help the parent involve a spouse in problem solving, learning to relate to children, and not being afraid to ask for help. Developing realistic expectations of small children and finding practical ways to find relief from their demands can be effective in reducing the potential for abuse. The goal of such parent re-education is the replacement of abusive behaviors with those that are effective as well as socially acceptable.

THE ABUSED

One of the most important concerns of the counselor is the psychological well-being of the abused child. Typically, the younger the child the better the chance of recovery from the psychological effects of abuse. Often small children quickly rebound following a family crisis and show continued love and affection for abusing parents. If removed from the home, the child is often eager to return.

The lasting effect of battering can take two forms: organic damage and behavioral manifestations. Paralysis and retardation are common results of severe beating, although more subtle damage to the central nervous system may appear as perceptual or learning difficulties and developmental delays.

Although physical damage is common, the counselor is more likely to deal with somewhat predictable problem behavior. Developmentally, the abused child learns complex and elaborate coping mechanisms which are generalized to extrafamily relationships. The typical behavioral themes found in the abused child are violence and withdrawal. Various forms of delinquency, passive resistance, and escape result from the violent parent-child relationship.

Another frequent manifestation can be described as negative self-concept and self-destructive behavior. Battered children often respond in a hopeless, depressed fashion: "I can't do anything right" or "I'm no good; why go on." Severe aversive self-stimulation in the form of drug use, suicide threats or nonviolent gestures, and thrill seeking can often be attributed to early abuse.

The task of the counselor in helping the abused child can be varied. Generally it is helpful to view the counseling strategy as the re-learning of behavioral mechanisms used to deal with people and society. The abused child's behavior differs from that of the unabused for very important reasons. The socialization process and social modeling generally drawn from parental interaction is deviant since aggression and violence are the theme.

The use of group counseling can be

a very powerful treatment mode in working with abused children. The groups provide an opportunity for the child to behave, interact, receive feedback, and observe more acceptable interaction models. Placing one or two abused children in groups with others can effectively facilitate the re-learning process.

The older adolescent, however, poses a slightly different problem. These clients can usually take full advantage of the opportunity to explore their feelings and emotions concerning earlier abuse. In a small group of previously abused adolescents the counselor must be prepared to help them deal with intense feelings of rejection and loneliness based on the assumption that their parents do not love them. In the majority of cases, this was probably a false assumption. Many child beaters value their children but simply do not know how to interact; nor do they have realistic expectations of young children. The counselor should attempt to explore positive home experiences and carefully avoid rejection of the parent. The goal of counseling is to help the abused deal with the rehabilitation of the family as a unit.

THE COUNSELOR AND THE COMMUNITY

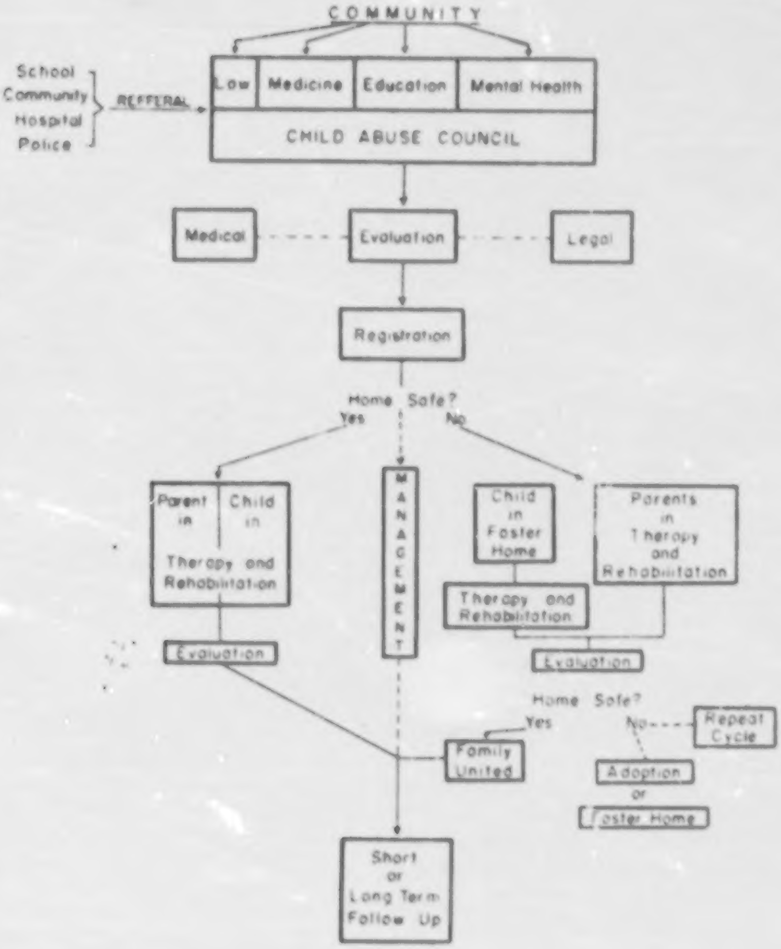
The uniqueness of the child abuse problem necessitates a community-based approach. Since school counselors are often on the front lines of case identification and therapy, it is incumbent upon them also to participate in the community response.

The local child abuse council has been a successful model used by many communities. Ideally, it includes a multidisciplinary representation of the professions of medicine, law, education, and mental health. The council's role generally involves case identification and reporting, management, and the coordination of its resources to help child and family. Often a council will go beyond the administrative function and establish ongoing therapy programs, foster homes, and educational programs.

Figure 1 graphically represents the function and community relationship of the child abuse council. Upon referral the council evaluates each case with specific consideration of medical implications and legal options involved. The case is then centrally registered, a useful procedure in the identification of chronic cases. If a determination is made that the home is not safe, the child is removed to a foster home situation. If the child is not in danger, the recommended therapy and rehabilitation program would begin with the child remaining in the home. The goal of the council's intervention is the rehabilitation of the family unit through the coordination of helping services.

Figure 1

Child Abuse Council Concept


COMMUNITY
School
Community
Hospital
Police
REFFERAL
Law
Medicine
Education
Mental Health
CHILD ABUSE COUNCIL
Medical
Evaluation
Legal
Registration
Home Safe?
Yes
No
Parent in
Child in
Therapy and Rehabilitation
MANAGEMENT
Child in Foster Home
Parents in Therapy and Rehabilitation
Therapy and Rehabilitation
Evaluation
Evaluation
Home Safe?
Yes
No
Repeat Cycle
Family United
Adoption
or
Foster Home
Short or Long Term Follow Up

RECOMMENDATIONS

Counselors do not see a child abuse case everyday. When such cases do appear, however, the response must be professional, quick, and effective. Counselors should prepare an outline of procedures to be followed when an abuse case is identified or suspected. Telephone numbers of referral sources, legally required reporting procedures, and medical resources should all be quickly available and current. The child abuse case demands a community response in which the school counselor plays an important role.

Counselors should engage in self-education and then provide information to the entire school staff concerning the child abuse syndrome. New and successful treatment programs should be evaluated and explored. Helfer and Kempe (1968, 1972) and the American Humane Association (P.O. Box 1266, Denver, Colorado 80201) are excellent resources.

Medical manifestations and legal considerations should be reviewed since all 50 states now have child abuse reporting laws. In most states reporting is mandatory, requiring professionals or others to report cases to the appropriate official agencies. Failure to report can result in legal action. However, all states grant immunity from civil and criminal liability to persons making reports of abuse cases in good faith. Local state laws, however, do differ regarding specific ages, conditions, and professional groups who must receive reports. Counselors should determine the specific law covering their state by contacting the office of their local attorney general.

Counselors should be encouraged to become involved or ensure the school's participation in an established child abuse council. If one does not exist, the school, specifically the pupil personnel office, should see that an appropriate community response is formulated.

Finally, an active, preventive mental health model should be pursued. It is important for counselors to become active in the education process to include curriculum revision and course development. Many future child abuse problems may be avoided through training and education. Specifically, children should learn useful child-rearing techniques and mechanisms to use when dealing with small children. The role of the family and family planning should also be studied. Additionally, children must learn how to deal with frustration and identify coping and adjustment mechanisms that will be useful in later life. Parent training clinics could be considered for adolescents and parents who are inadequate in child rearing. Behavior modification training programs such as Parent Effectiveness Training provide useful models to follow. Counselors may be central in providing training or initiating such programs.

The battered child syndrome is a real and complex community problem. School counselors can make significant differences in the outcome of such cases and then help prevent child abuse in the future.

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Preventing Child Abuse

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It has been said that a society "succeeds or fails in direct proportion to the way it enhances or impedes the development of its children" (Noshpitz, 1974, p. 96). As is evidenced by the 1974 enactment of the federal Child Abuse Prevention and Treatment Act (Pub. L. No. 93-247) and similar legislation in various states, our society is currently attending to the problem of child abuse. This attention offers us an opportunity to look closely at the way we enhance or impede the development of our children.

When a problem like child abuse captures the attention of a society, the manner in which the society analyzes the problem reveals a great deal about its overall commitment to the development of children. Society's analytic approach defines the problem. By identifying those actions and attitudes directed toward children that the society considers to be abusive, the society reflects its values about children. From these definitions and values emerge the types of legal and social interventions that the society is willing to take in order to eradicate the problem of child abuse.

The first part of this article is concerned with two major and general approaches to analyzing the problem: (a) the comprehensive approach, which defines child abuse as being collective, institutional, and individual in nature; and (b) the narrow approach, which considers only individual abuse. A short section follows on the prevention implications of these approaches. An extended discussion of the individual physical abuse of children then occurs, with particular emphasis on the relationship between theoretical formulations of the causes of individual physical abuse and programs that have the potential for preventing physical abuse. Finally, the successful reinforcement of these programs is discussed as a step in the direction of raising public consciousness about all forms of individual as well as institutional and collective abuse.

Values and Analytic Approaches

The comprehensive approach attempts to make its values about children as explicit as possible and defines child abuse in a broad sense (Gil, 1973). This approach stresses that children have rights comparable to other members of our society. It states that,

> Every child, despite his individual differences and uniqueness, is to be considered of equal intrinsic worth and hence should be entitled to equal social, economic, civil and political rights, so that he may fully realize his inherent potential and share equally in life, liberty and the pursuit of happiness. (Gil, 1973, p. 7)

In addition, the comprehensive approach takes a strong position of value by asserting that children also have rights to the fulfillment of their developmental needs. It asserts that it is a child's right to have the opportunity to have his psychological and physical needs fulfilled.

On the basis of these values regarding the rights of children, the comprehensive approach considers the violations of children's rights as constituting child abuse. It defines child abuse as follows:

> Any act of commission or omission by individuals, institutions, or society as a whole, and any conditions resulting from such acts of inaction, which deprive children of equal rights and liberties and/or interfere with their optimal development. (Gil, 1973, p. 7)

Embedded in this definition are three types of child abuse: (a) collective, (b) institutional, and (c) individual.

Collective abuse refers to those attitudes held collectively by our society that impede the psychological and physical development of children. Examples include the racial and social class discriminatory attitudes of our society that are reflected in our continued toleration of the substandard child-rearing environments that exist in most ra-

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cially segregated and economically impoverished neighborhoods in the United States (Birch & Gussow, 1970; Chess & Thomas, 1970; Deutsch, Katz, & Jensen, 1968; Hunt, 1969; Hurley, 1969; Jones, 1972). Seven million children in the United States are being raised in the abusive child-rearing conditions of poverty (U.S. Bureau of the Census, 1972). Collective abuse also includes those adult supremacy attitudes about the status of children that contribute to the denial of certain legal rights to 67 million children and youths under the age of 18 (Paulsen, 1974). These adult supremacy attitudes also contribute to the toleration and widespread use of physical force as a means of disciplining and controlling children (Gil, 1970). When directed toward adults, these means are illegal and considered personally demeaning.

Institutional abuse refers to abusive and damaging acts perpetrated against children by such institutions as schools, Head Start agencies, juvenile courts and detention centers, child welfare homes and agencies, correctional facilities, and other institutions with responsibilities for children. Some specific examples include policies and practices that promote the use of physical force with children (Bandura, 1973) and policies and practices that promote cycles of psychologically damaging separations for those children who are fated not to be born into even minimally stable family environments (Goldstein, Freud, & Solnit, 1973; Yarrow, 1964).

Individual abuse refers to the physical and emotional abuse and neglect of children that results from acts of commission or omission on the part of parents and other individual caretakers. Some specific and extreme examples include the nonaccidental infliction on children of such injuries as the fracturing of limbs and skulls, the sexual molestation of children, and the emaciation of children (Helfer & Kempe, 1968/1974; Leavitt, 1974). Individual abuse occurs with children of all ages, within all ethnic and geographic groups, and at all socioeconomic levels. It is estimated that from one to four million American children are abused in these ways by their individual caretakers (Gil, 1970; Light, 1973).

Through its broad perspective on society's attitudes, actions, and inactions, the comprehensive approach indicts all of us as intentional or unintentional contributors to the abuse of our children. This approach represents a sweeping accusation of our negligence in protecting the rights, health, and development of all children.

The indictments of this comprehensive approach are extremely difficult for our society to deal with because we generally consider ourselves to be a child-centered society (Rodham, 1973). It is probably this type of psychologically threatening challenge to a fundamental myth about our society that contributes to our being more favorably disposed toward a narrower approach to the problem of child abuse.

The narrow approach does not attempt to make explicit its values about children. This approach defines child abuse in a restricted sense because it does not include collective or institutional abuse in its definition. It limits its definition only to individual abuse on the part of parents and other individual caretakers (Helfer & Kempe, 1968/1974; Leavitt, 1974).

It is the narrow approach to the problem of child abuse that is reflected in the federal Child Abuse Prevention and Treatment Act, in most state child abuse acts, and in the child-abuse-reporting statutes (Light, 1973; Paulsen, 1967). This is so because the statutes, federal act, and most state acts fail to explicitly enunciate values concerning children and fail to explicitly recognize the existence of collective and institutional abuse.

Prevention of Child Abuse

With regard to preventing child abuse, the comprehensive and the narrow approaches raise markedly different issues.

From the perspective of the *comprehensive approach*, the implications for the prevention of child abuse are as sweeping as the previously mentioned accusations. To prevent child abuse in its three forms would require major changes in how we think about children: changes in attitudes toward children and in attitudes that affect the development of children. It would require major modifications in how we behave toward children and major structural and procedural changes in all the institutions that affect the development of children (Gil, 1970, pp. 133-148).

From the perspective of the *narrow approach*, the prevention of child abuse (i.e., the prevention of the individual abuse of children) gives the appearance of being more readily obtainable. And because it is this approach that is reflected in how our society is currently dealing with the problem of child abuse, I focus here on some issues and programmatic suggestions about preventing individual abuse. This discussion centers on only one form of individual abuse, *physical abuse,* because it is this form that has received the most attention to date.

In focusing on the prevention of individual physical abuse, I am relying on the preventative concepts from the public health field. In this context, primary prevention refers to the prevention of physical abuse before it occurs. It refers to a before-the-fact or preincidence intervention. It is designed to forestall the physical abusing of children, or, conversely, it seeks to promote the caring of children. Primary preventative interventions are directed toward parents and other individual caretakers and toward the environmental conditions in which child caring takes place.

Secondary prevention is an after-the-fact or post-incidence intervention. Its aim is to shorten the duration, impact, and negative aftereffects of physical abuse by placing heavy emphasis on early identification and prompt treatment of abuse. Secondary preventative interventions are directed toward the abused child, the abusing caretaker, and the environmental conditions in which the abuse took place.

Primary prevention programs and services will have to compete with secondary prevention programs and services for the available federal and local child abuse monies. This will be powerful competition because of the pressing immediate need for secondary prevention services. Each individual case of physical child abuse requires a wide range of prompt treatment, rehabilitation, legal, educational, and/or social services. The abused child always requires extensive medical and/or psychological services. The child often needs placement services for temporary or permanent removal from the home. All of these services are needed not only to help the child survive childhood but also to help prevent him from becoming an abuser of his children. The parents also require some form of immediate treatment, rehabilitation, or reeducation to forestall the continued abuse of their children. If the abuse occurs within a poor or unemployed family, a whole range of additional social and vocational services is often necessary. Personnel in the service delivery systems are often untrained, undertrained, or unsupported in dealing with these emotionally demanding cases of individual physical abuse. There is a great need for more training and support of personnel who deal with these cases. Thus, it seems likely that the pressing need for secondary prevention services and related activities will be such that very little child abuse money will go toward the creation of primary prevention programs and services.

If this is so, we will probably have to look at already existing programs and services and support those elements of the existing programs and services that have primary abuse prevention potential. We will have to have some ideas about which programmatic elements have primary abuse prevention potential. Some ideas in this regard might be gleaned from the current formulations about the factors that cause or contribute to the cause of individual physical abuse. These causal formulations are based mainly on clinical observations and/or on currently sparse research data.

Causal Formulations

Most current formulations about the causes of physical abuse differ in terms of the emphasis placed on psychodynamic as contrasted to sociocultural factors. This differential emphasis seems to be as much a product of the disciplines of the formulators as it is a product of the wide variety of factors that appear to be of causal importance in different cases of physical abuse.

Formulators from disciplines that have traditionally focused on internal factors as the major cause of deviant behavior (medical/psychiatric and clinical psychology disciplines) have emphasized personality defects in the caretakers (Adelson, 1961; Allen, Ten Bensel, & Raile, 1969; Elmer, 1967; Fontana, 1972; Helfer & Pollack, 1967; Holter & Friedman, 1968; Kempe, 1968; Kempe & Helfer, 1972; Kempe, Silverman, Steele, Droegemueller, & Silver, 1962; Paulson & Blake, 1967; Silver, Dublin, & Lourie, 1969a, 1969b; Spinetta & Rigler, 1972; Steele & Pollack, 1968). These formulators have presented evidence to indicate that many physically abusing caretakers have a general defect in character that allows for "aggressive impulses to be expressed too freely. During times of additional stress and tension, the impulses express themselves on the helpless child" (Spinetta & Rigler, 1972, p. 301).

A typical psychodynamic description of physically abusing parents that emerges from these formulators is as follows:

> there is a childhood history of physical or emotional neglect or abuse in the parents own life. Stemming from this are feelings of low self-worth, high (and often frustrated) dependency needs, and low feelings of affiliation. There is often an unrealistically high demand for performance from children, and infants may be regarded as an important

> and unrealistic source of love and reassurance about personal adequacy. Thus, a crying infant or disobedient child is apt to be seen as rejecting, evoking anger and punishment from the parent. (Kent, Note 1)

On the basis of this type of psychodynamic formulation, it has been proposed that it should be possible to develop psychological profiles that differentiate abusers from nonabusers. For example, if abusers differ markedly from nonabusers on such characteristics as demand for performance from children or aggressive impulse control, it should be possible to construct assessment instruments that differentiate caretakers along these dimensions. If such instruments were to be developed and administered to all caretakers, it could be possible to predict the abuse potential of caretakers and then to intervene preventively where there are high-abuse-potential caretakers before physical abuse occurs.

This type of primary prevention strategy is a logical extension of the narrow approach to child abuse. Its implementation would raise complex moral and legal issues, particularly with regard to intervention in instances of true-positive and false-positive cases. Its implementation would probably also have the dubious side effect of deflecting attention and public responsibility from factors other than psychodynamic ones that contribute to physical abuse.

Formulators of the causes of physical abuse who represent disciplines that have traditionally focused on external factors as the major cause of deviant behavior have emphasized the causal or contributory role of social, cultural, and economic environmental factors. This formulation places particular emphasis on the environmental stresses that impinge upon caretakers and that are associated with a large number of physical abuse incidents. Financial and emotional family stresses that are related to unemployment, large families, and social isolation have been shown recently to be connected to most instances of physical abuse (Light, 1973). This finding and others indicating that the reported incidence of physical abuse is higher within low socioeconomic communities (Gil, 1970, 1973; Kent, 1972) lead sociocultural formulators to emphasize environmental stress as a major causal factor and to contend that the actual incidence of abuse is higher in poverty communities because of the greater degree of stress in daily living that exists in these communities.

For the psychodynamic formulators, findings regarding these types of environmental influences are interpreted to indicate that "socioeconomic factors sometimes place added stress on the basic weakness in personality structure, but these factors are not of themselves sufficient or necessary causes of abuse" (Spinetta & Rigler, 1972, p. 302).

It would seem that arguments regarding the relative primacy of sociocultural or psychodynamic factors are of limited utility. As Gil (1970) has pointed out, the physical abuse of children is not a uniform phenomenon with one set of causal factors, but a multidimensional phenomenon. It is a phenomenon of uniform symptoms but of diverse causation. Many perpetrators do possess the psychopathological character structures indicated by psychodynamic formulators, while others do not. Many perpetrations seem undeniably to be a result of overwhelming environmental stresses, while others are only partially influenced by these external stresses.

In addition to character defect and environmental stress factors, several other factors have been shown to contribute to causing physical abuse (see Gill, 1970). These factors include deviant or atypical precipitating behaviors on the part of the abused child, environmental chance factors that may transform an otherwise ordinary disciplinary encounter into a tragic event, disturbed intrafamily relationships involving conflicts between spouses and/or rejection of individual children, and combinations among these sets of factors.

However, the factor that influences all instances of physical abuse, and upon which all other contributory factors are superimposed, appears to be a general, culturally determined permissive attitude toward the use of physical force in caretaker-child interactions. This is the conclusion reached by Gil (1970) on the basis of the results of a series of nationwide studies on physical child abuse that was supported by the U.S. Children's Bureau.

Gil contends that the approval of a certain measure of physical force as a legitimate and appropriate educational and socializing technique is endemic to American culture. Gil also observes that there are differences between various segments of American society concerning the quantity and quality of physical force that is approved of and actually practiced. For example, families of low socioeconomic and educational status tend to use corporal punishment to a far greater extent than do middle-class families. In addition, he notes:

> Also, different ethnic groups, because of differences in their history, experiences and specific cultural traditions, seem to hold different views and seem to have evolved different

> practices concerning the use of physical force in child-rearing. (p 134)

Gil further observes that the

> excessive use of physical force against children is considered abusive and is usually rejected in American tradition, practice and law. [However, there are] no clear cut criteria concerning the specific point beyond which the quantity and quality of physical force used against children is to be considered excessive. (pp. 134–135)

Thus, there exists a general cultural toleration of a measure of physical force in American child rearing. There are qualitative and quantitative differences among various subcultural and social class groups in the approval and practice of this measure. There are no clear-cut criteria concerning the point beyond which the measure becomes excessive. And it is this situation out of which the other contributing factors realize their destructive ends.

This discussion of the factors that contribute to the physical abuse of children was stimulated by primary abuse prevention concerns. Specifically, the purpose for exploring these factors and related issues was to arrive at some ideas about which already existing programs and services might be bolstered to assist in the primary prevention of physical child abuse. The programs and services to be reinforced would be those that directly or indirectly address themselves to the contributory factors.

Programs with Prevention Potential

The Education for Parenthood program (Kruger, 1973; Marland, 1973; Rosoff, 1973), which began in 1972 as a joint venture of the U.S. Office of Education and the Office of Child Development, strives to help teenage boys and girls prepare for effective parenthood through high-school-based educational experiences about child development and the role of parents, and by participatory-observation experiences with young children in day care, nursery school, and kindergarten settings. This program has primary abuse prevention potential for several reasons. Its exposure of teenagers to the stages and processes of human development, both through classroom and field experiences, may influence the expectations of these future parents regarding children's emotional and cognitive capabilities at various stages of development. The exposure to child care workers who are sensitive to the needs of children, who are capable of appropriate channeling of aggression, and who are successful with children without having to use physical force creates excellent observational learning opportunities for these prospective parents. It is possible that completion of these experiences will lead the future parents to be

> sensitive to the central importance of parents in the child's life, to individual differences among children and to the broad range of nutritional, medical and psychological conditions that must be satisfied for a child to develop to his full potential. They will know that there are places to turn for personal help, that there are clinics and other local resources for prenatal and infant care, and that there are agencies that offer helpful publications. (Cohen, 1973, p. 29)

It is also possible that they will have learned to look for such guidance during early pregnancy or even before. "And, perhaps most important, adolescents who have benefited from an Education for Parenthood course will be aware of the value and methods of family planning" (Cohen, 1973, p. 29).

The abuse prevention potential of the Education for Parenthood program could be increased by making the program available in all high schools and by providing additional support and consultation to the teachers and child care workers in the program. Such support and consultation would seem necessary to help the teachers and child care workers deal more effectively with the personal concerns and feelings of the teenagers as they go through the program. The support and consultation could be provided by appropriately trained personnel within the educational setting or from consultants from such agencies as community mental health centers. This additional support and consultation could also be used to raise the level of consciousness of the teachers and child care workers regarding the problem of physical child abuse.

The Office of Child Development's Home Start program also has abuse prevention potential (see O'Keefe, 1973). This program, which is currently being developed and evaluated in 16 cities, sends specially trained visitors into the homes of economically disadvantaged families who have three- to five-year-old children. These home visitors deliver or initiate a wide range of services such as helping the families identify health problems of their children and referring families to appropriate services; helping families assess and meet their nutritional needs; helping parents identify their personal and relational needs and helping them seek out appropriate community services such as employment counseling, diagnostic testing, job training, drug counseling, and psychotherapy; helping enhance parents' knowledge and understanding of early childhood development; and helping parents learn how to reinforce their children's positive behaviors.

Because of the range of helping services that these home visitors can deliver or initiate, it is likely that the visitors will develop a good deal of credibility and legitimacy with the families. From this position of legitimate authority, these home visitors certainly could become important partners with the families in preventing physical child abuse.

The abuse prevention potential of the Home Start program could be bolstered by providing home visitors with education and training in the issues and factors related to physical child abuse so that they would become more conscious of and attentive to those aspects of their work which are addressed directly to these issues and factors. These home visitors could also visit homes with children under the age of three. Visitors could draw on the procedures of the infant-stimulation-through-parent-education programs for some additional infant-oriented services (Gordon, 1969; Howard, 1972). By extending the use of these visitors into the homes of infants, the Home Start program would maximize its potential for the prevention of one of the more hideous types of individual abuse, the battering of infants.

The Home Start program grew out of the nationwide Head Start Project. Head Start began in the 1960s. It consists of one-year programs that provide health, nutritional, educational, social, and psychological services to economically disadvantaged preschoolers (Zigler, 1973). Head Start programs are now under the direction of the Office of Child Development. They are based in local centers rather than in the home. Because these programs are located in poverty communities, they deal with the populations that experience the greatest amount of environmental stresses and in which there exists the highest reported incidence of physical child abuse. The existence of Head Start programs has already been shown to have primary abuse prevention potential because the programs serve as catalysts for communities to improve their educational, health, and social services to the poor (Zigler, 1973). To the extent that they actually involve parents in meaningful ways and model nonphysical force methods of interacting with children, these programs have many other physical abuse prevention capabilities. These potential capabilities can be encouraged by providing the staffs of Head Start programs with relevant education and training. Such education and training could emanate from the children's services of local community mental health centers as well as from other local educational and training agencies. The avowed partnership for children between the federal agency that sponsors Head Start and the federal agency that supports the community mental health centers (the National Institute of Mental Health) could be actualized to reinforce Head Start's abuse prevention potential.

The children's services of the community mental health centers could deliver mental health education services to parent groups in churches and schools regarding the issues and factors that contribute to physical abuse. As mentioned previously, they could work more closely with prospective parents, new parents, and key social agents who are in contact or influence prospective and current parents.

The public school system's adult education programs could offer parent-training courses that stress alternatives to the use of physical force with children. There are several of these types of parent-training courses that have been successful in teaching parents nonpunitive approaches with children. Two of these courses are the behaviorally oriented child management courses (Becker, 1971) and the parent-effectiveness-training courses (Gordon, 1971). These courses have an additional abuse prevention potential. They often result in the parents developing close relationships among themselves. They meet outside of the training sessions and turn to each other for help during times of marital and financial stress. This natural parent grouping with its social-isolation-diminishing features obviously has untapped prevention potential.

The programs described above are by no means the only existing ones that could be bolstered because of their potential to prevent physical abuse. There are other programs at the federal, state, and local levels that address themselves to the contributory factors and whose reinforcing should help prevent physical abuse.

Assessing the Impact of Physical Abuse Prevention Programs

One direct means of evaluating whether the bolstering of these types of programs would be effective in preventing physical abuse would be to analyze the incidence data on physical abuse. If the incidence of physical abuse decreased after the programmatic reinforcements, then there would be evidence that suggests effectiveness.

However, there are many difficulties in using incidence data. It is generally agreed that the reported incidence of all types of individual abuse is severely underrepresentative of the actual occurrence (Light, 1973). This is due to (a) variable reporting requirements in each state, (b) a generally low level of public and professional consciousness about the need to report, and (c) a lack of knowledge and/or confidence in how reporting can be of benefit to the abused child and his or her family. Thus, in conducting a pre- and postincidence analysis of whether abuse prevention programs are effective, the evaluators would have to qualify all statements as a result of severe underreporting. They would also have to consider the possibility that *increases* in the reported incidence may be indicative of program effectiveness, because an increase may reflect heightened awareness of the problem and greater knowledge and confidence in the institutions that are responsible for managing child abuse cases.

Another means of assessing impact is to look for indirect and long-term effects. As has been suggested, if the above and other similar programs were encouraged to specifically address themselves to the prevention of physical abuse, it is likely that public consciousness would be raised markedly. It is also likely that such an increase in public awareness would lead to more discussions of the other types of individual abuse, such as sexual abuse, severe neglect, and emotional abuse.

Overall consciousness raising in the area of individual abuse should lead to the further awareness of the existence of institutional and collective abuse. When we as a society reach this level of awareness, we may move away from the narrow approach to child abuse and approach this problem from a comprehensive perspective. When we do this, we will have to make a national commitment to invest large sums of money for the prevention of the three forms of child abuse or, put more positively, for the improvement of child caring. However, the overall improvement of child caring not only requires a commitment to invest monies but also a commitment of spirit. Only a commitment of spirit will support the allocation of the necessary monies to improve child caring. Only a commitment of spirit can reverse what has been termed our "cultural recalcitrance toward assuming public responsibility for children's needs" (Rodham, 1973, p. 492).

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understanding
comes first
in helping . . . .

the ABUSED parent of the ABUSED child

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SIDNEY WASSERMAN

Willful intent in parents to injure their own children is an "unthinkable thought" for most of us. Even physicians, persons who seem to be in a position to judge whether violence has been done to a child, are often unwilling to accept the "reality of willful child abuse," according to a recent survey among physicians in the Washington metropolitan area conducted by a group of psychiatrists.[1] A fifth of the nearly 200 physicians questioned said they rarely or never considered the "battered child syndrome" when seeing an injured child, and a fourth said they would not report a suspected case even if protected by law against legal action by the parents. Apparently, they did not believe the evidence would stand up in court.

To accept as fact that some parents intentionally injure their children is difficult and upsetting. Thus, we all tend, like the physicians studied, to give the parent "the benefit of the doubt." There may be many reasons for our reluctance, but one is certainly this—when we accept willful intent as a fact, we must face our anger at such parents and our desire to protect the child, even if we harm the parent. But we cannot effectively intervene to protect an abused child and prevent abuse from recurring unless we understand what it is like to be a "battering parent."

One of the dangers of using the label "battering parent" is the possibility of increasing bias and prejudice against the parent. Labeling a particular person as a "battering parent" can release us from the responsibility of making our response to and attitude toward his actions sensitive to his needs. The temptation is great to think of him as being far removed from those of us who do not batter our children. In so thinking, we keep intact our image of ourselves as righteous.

How easy it is to deny that within all of us lies a potential for violence and that any of us could be unreachable! What is more repugnant to our rational, "mature" minds than the thought of committing impulsive, violent acts against a helpless child? We tell ourselves that the primitive, untempered instincts responsible for such acts could not erupt in us. But stripped of our defenses against such instincts and placed in a social and psychological climate conducive to violent behavior, any of us could do the "unthinkable." This thought should humble us: perhaps we are not battering parents only because conditions do not lead us to commit "unnatural" acts.

No class monopoly

Writers on social phenomenon, lawyers, social scientists, and others interested in social problems have long recognized that the phenomenon of parents physically abusing their children has been with us since the beginnings of mankind. Only since World War II, however, has much been written on the subject of unexplained, shocking, and traumatic injuries to children. Since then, too, much has been said and written about the legal confusion surrounding the use of authority and sanctions in instances of apparent abuse of children by their parents.

Historically, the helping professions have viewed physical abuse of children by their parents as the result of poverty, life in the slums, ignorance, and the hardships produced by immigration, war, industrialization, and urbanization. No one can deny that these conditions can be a cause of child abuse. Nevertheless, we are finding that the phenomenon can be found anywhere in society. Once we regarded violence against a child as characteristic of parents in the lower socioeconomic classes. Now we are finding that such behavior is not exclusive with any particular social class but that "better" families can more easily conceal the problem than poor ones. In other words, a sociological explanation by itself is inadequate and simplistic.

Through sometimes frustrating and bitter experience, the professions, and particularly that of social work, have come to see that prosecuting the battering parent solves the problems of neither the child nor the parent. Helping the abused child leads us inevitably to the need to help the battering parent and family. As pointed out by Delsordo,[2] Boardman,[3] Nurse,[4] and others in studies of child abuse, practically all cases of abuse involve longstanding, severe interpersonal conflict either between the parents themselves or between one parent and another member of the family.

Because we are dealing with a complex subject involving many social, psychological, medical, and legal elements, we must narrow our scope and take first things first. Nothing precedes understanding who the battering parent is and what he is. Studies point out that battering parents and families, regardless of class, have certain psychological and social characteristics in common; for example, we are learning more all the time about the severe damage to personality these people suffer. Few are psychotic, but all have marked inability to set up a genuine relationship with another human being. Absorbed by their own hurt feelings, they cannot sympathize with the feelings of others. The nonpsychotic battering parent seldom shows remorse for having hurt his child, but he can be very much concerned about the harm a person in authority might inflict on his own person. When facing a person in authority, he cries out: "What are you going to do to me?"

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"Done to"

Obviously, something went haywire or was not touched in the humanization process when such persons were growing up. Apparently, they never had the kind of relations with other people that offers incentives for delaying pleasure or gratification or the feeling that it is worthwhile to yield an immediate, antisocial pleasure for the love and acceptance of another. They have been "done to" both socially and psychologically. A battering adult goes about his daily life with the gnawing, unfulfilled feeling of having been unloved or not having been loved as much as he should have been as a child. His life is focused on his own needs, and he cannot tolerate any frustration to the gratification of those needs. What else can he feel but his own hurt, his own hunger for love? He is anesthetized against feeling compassion for others.

This kind of person, according to Reiner and Kaufman,[5] is unaware that he has a buried feeling of "imbedded depression" because he was emotionally or psychologically abandoned by his parent as a child, an act he interpreted as rejection of himself. Unable to understand such a distressing emotional event and not psychologically strong enough to bear it, as a child he buried the feeling of rejection deep within himself and with it the accompanying depression. Because his use of language was not developed, he expressed his feelings by the only means he had—his behavior. Explosive, violent behavior became his means of communicating with those around him. When he was violent, he was unable to feel his hurt, his sense of worthlessness, his depression. Denied a consistent, supportive relationship with an adult, he set up a life pattern of aggression and violence—and is now inflicting on others what was inflicted on him. For him the world is hostile and dangerous; it is a place where one attacks or is attacked.

Studies also suggest that the battering parent feels his parents were punishing him when they rejected him and that he is longing for a mother. He wants to be loved, yet does everything to prevent another from loving him. Instead, he is caught in a cycle of violence and rejection. When speaking of his physical attacks on his child, the battering parent strongly defends his right to act as he has. He seems unable to feel love for and protectiveness toward his child. He can be extremely compulsive in his behavior and make unreasonable demands on his child. Cleanliness, for instance, may be an obsession with some. I have heard of a child being mercilessly beaten for putting chicken bones on a clean tablecloth and of an 18-month-old baby being seated with his buttocks uncovered on a hotplate whenever he soiled himself. Such people are way over their heads when they become parents. How can they give a child what they have never had themselves—security, safety, and love?

The hostility sponge

This description is supported by a growing amount of evidence that when a battering parent becomes violent, he apparently is releasing his rage on a particular child, selected to act as the "hostility sponge" for that rage. The parent views the child as a competitor, as someone taking and getting what belongs to him. The child is an unconscious symbol of someone or something that once caused him pain—a competitive brother or sister, a distrusted parent, his rejected self. Sometimes the parent is reliving a childhood experience that left him traumatized. Some of these parents talk about being rejected by their own parents in favor of a brother or sister.

In many instances the abused child has been conceived out of wedlock. The parent is now punishing him for being the cause of an unwanted marriage. Sometimes a stepfather is the offender. He beats the child for reminding him of his wife's "badness." Or the mother may beat the child because he reminds her of her "badness" or of that "bad" man, his father, who deserted her when she was pregnant. By beating out the "badness" in the child, the parent beats out his own badness or that of another person who has injured him. In other words, the parent is reacting to his own inner feelings, not to the behavior of the child. The child is the provoker by being what he is—an infant or a child demanding attention. It is this demand that provokes the parent.

The use of the child as a hostility sponge may be absolutely essential to the mental balance of the parent, and, thus, the child is sacrificed to that mental balance. Removing the child from the home without a well thought-out plan to help the parent and the family may only invite the parent to shift his rage to another child. We can easily get caught up in symptom-shifting without getting to the bottom of the problem—the parent's need to be protected from himself.

To really help such a parent, we must break the chains he has inherited. To do that, we must clearly understand that intervention should act as a brake on the parent's behavior and that the injuries he inflicts on the child, injuries that bring the attention of the community to join them, are his way of saying—"Stop me!" The act of rushing a child to a hospital or of beating him in front of neighbors or strangers carries a message to the community—"Please save me from going out of control. Stop me from going out of my mind. Keep me from—killing!"

We are gradually realizing that in such cases we are dealing not only with a seriously disturbed person but also with a disturbed family. Once the existence of abuse is ascertained and the degree of imminent danger determined, the parent and the family must be dealt with whether or not the child is removed from the home. Even in cases where law enforcement has been effective and community services have been well coordinated, problems in helping the battering parent and the family remain.

According to Zalba,[8] battering parents tend to deny their actions, the husband or wife of the battering parent protects the other, or the children are too young to explain to outsiders what has occurred in the home. The parents also tend to deny the existence of personal or family problems and to provoke judges, lawyers, and social workers by making impossible demands on them; or they rage at everyone in authority and, sometimes, physically attack them.

Firmness above all

In reaching out to the battering parent, we must keep in mind an important key to his behavior—his fear of a close relationship. Because he suffered rejection in early life, he wards off human relationships. He has emotionally divorced himself from the significant people in his life. He feels safer with and responds more readily to a relationship that clearly offers authority—firm but not punitive. In other words, the battering parent can often be reached by setting firm limits and controls on his behavior. Whatever he may say, he needs firm control—and wants it. In the early stages of trying to reach the battering parent and family, the social caseworker or other helper must make realistic judgments and decisions for and with the parents and family to gradually help them develop a sense of reality.

To provide this basic treatment requires long-term help from a consistent relationship with one person only. Shifting the parent from one worker to another only stirs up his basic, deep-seated belief that to get close to another human being is to expose one's self to hurt and abandonment. Deep within, he sees himself as the kiss of death in personal relations. He wants to get close to another person, but he thinks that if he does the person will learn to dislike him and will break off the relationship. For a long, indefinite period, the helping person must stand by and support the parent by setting limits and by providing services through community resources. He must not try to get too close to or expect such a person to unload his innermost feelings, especially feelings he is hardly aware of. For such a person, having limits set on explosive, violent behavior provides the kind of protection a good parent would give. The battering parent must be constantly assured that he will not be allowed to get out of control. At the same time, he must be assured that the worker believes that he does not want to hurt his child, that he is capable of change, and that he wants to be a better parent. He needs to learn what the community expects of him and what choices he has. He needs to be helped to understand clearly that consequences will follow his violent act and what those consequences will be.

A long process

In this long and trying process, such a parent will continually test the patience of the helping person and will use every means to provoke rejection to reassure himself that he will not be rejected. For a long time he will reveal only his unlikeable side. When he is reassured, he will make feeble attempts to plant the seeds of a relationship. Reaching out to such a person makes a very great emotional and intellectual demand on the helping person. The battering parent is very perceptive and can immediately sense insincerity. Actually, the helping person must become the "hostility sponge" instead of the child by letting the parent test him, yet he must never let the parent get out of control.

Psychiatrists, psychologists, social caseworkers, and other persons trained for this work have observed that as treatment progresses and a basic trust is established the battering parent gradually faces up to the depression within himself. With extreme caution, he talks about his deep-seated fear that he is a loser and that people always desert him. Only when his need for violence abandons him and he stops expressing himself through it can he talk about his childhood and begin to come to grips with his problems. Though he improves, he continues to try to provoke the helping person, for he is never convinced that he will not be rejected. However, he does move cautiously toward having a relationship with the helping person, gives up or modifies his violent outbursts, and lets himself be guided toward patterning his actions after the standards of the helping person. In time, the pattern becomes a part of him and a new self appears.

To start and set in motion such a long, painstaking process requires a firm commitment by the community to providing excellent service, a goal not easily attained. To obtain qualified staff members and to train persons specifically as workers are expensive and time-consuming. Often efforts to reach the battering parent are obstructed because workers—nurses, social workers, volunteers—come and go frequently on the staffs of agencies. For the battering parent is likely to regard a change in workers as another experience in rejection. The helping person may leave the staff at the most critical moment—just as the parent is testing the worker to find out if rejection will follow his actions. The parent takes the worker's leaving the agency as proof that it never pays to get close to another person. If only a community or agency could insure permanent service for such troubled human beings!

But life affords few opportunities for permanency. We are all only temporary to each other. That is a human condition, and most people accept it. The battering parent cannot. Plans for helping him must include ways to help him accept this truth. We must be ready to test various methods of working with him, always keeping in mind his deep fear of involvement and loss. We must continue to direct efforts to alert the medical, legal, and social work professions, and all groups who might come in contact with the battering person to the need for continuity in helping him. The challenge is not a small one: social workers are finding that cases involving battering parents as well as other hard-to-reach families are making up more and more of their caseloads.

In addition to individual treatment, working with groups of battering parents and their spouses is also proving effective. Many of these parents are isolated from the community. Having an opportunity to socialize in a group of similarly troubled persons tends to lower their resistance to facing and dising their problems.[5] Working with such families as family groups has also proved effective.[6]

The community must learn

Beyond the abused child, his parents, and his family is the community around them. Battering parents and their families suffer from a not uncommon malaise often called "community exclusion." In various ways, whether economically, politically, psychologically, or socially, these families frequently suffer exclusion. Unfortunately, when such persons vent their rage on their children and the shocked community retaliates immediately, the family's sense of rejection is increased. A cycle of reciprocal aggression is set in motion and, once set in motion, is difficult to halt. The battering parent often succeeds in provoking hospitals, the police, the courts, and social agencies into treating him as his parents once treated him—the opposite of what he needs. Communities must constantly reexamine ways to set up controls and limits while bringing all families into the community life. When a battering parent has only known "community exclusion," he desperately needs "inclusion" to break the cycle.

Finally, we cannot examine our attitude as a community toward the battering parent without examining what it means to be part of a whole—a State, a nation, or the world. Like it or not, we are bound each to the other and our destinies are interwoven. As we try to understand the battering parent, we must look into ourselves to find out what there is in each of us, in our community, our Nation, and the world that the battering parent takes as a sign that what he is doing is permissible.

To answer this question we must face up to the paradoxes in our moral code that condemn violence in one form, permit it in another. Many Americans seem to persistently dismiss from their thoughts and acts a basic truth—there is nothing more precious than human life, or so it seems to me.

The people of the United States have yet to learn how to convert their tendency to violence into compassion and tenderness. We are in danger of losing sight of one of this Nation's major social goals, one on which it was founded, that is, to tap the humanity and creative potential of all citizens and to provide the environment and resources necessary for the individual citizen to realize his creative potential. We possess the potential both for violence and for humaneness, and are capable of acting in brotherhood and with understanding. If this were not so, we would not now be seeking new and different ways of helping our less fortunate citizens. By seeking to tap the humanity and potential for growth of the battering parent and family, we are tapping our own potential for personal, community, national, and international growth. We must ever encourage the tapping of this potential.

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the rights of children

BY JERRY M. WIENER, M.D.

In an editorial on May 20, 1971, the *New York Times*, in a criticism of the cuts made by New York State in its budget for the Department of Mental Hygiene, commented that the treatment of the mentally ill, the brain injured and the mentally retarded "is a test of how humane any society really is." Using this standard, it is worth asking how our society meets the test. How do we respond to the needs of our children, and particularly those children who are in some way different, deviant or disadvantaged? This group would include the emotionally disturbed, the mentally retarded, brain injured and behaviorally deviant.

The White House Conference on Child Health and Protection proclaimed that "the emotionally disturbed child has a right to grow up in a world which does not set him apart, which looks at him not with scorn or pity or ridicule but which welcomes him exactly as it welcomes every child, which offers him identical privileges and identical responsibilities." This is certainly an enlightened and noble statement. It is sobering to realize that it was made at the White House Conference in 1930, and if anything we are today further away from securing those rights than we were then.

Let us put the problem in perspective by reviewing some of its truly staggering dimensions. Fifty per cent, or about 100 million of our population, is now under 25 years of age. Of these, about 80 million are 18 or under. Twenty million of these children and youth are growing up under circumstances defined as poverty. Since the ratio of white to minority groups in poverty is one to four, we can estimate that there are 16 million minority group children growing up in poverty of whom the great majority are black and therefore the victims of poverty and racism combined. Now, of all our children (80 million) a probably conservative estimate of 12 per cent *(10 million)* have some significant psychological and/or developmental disturbance. Of these 10 million almost a third

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(2.4 million) are estimated to have a serious mental illness such as childhood psychosis or severe developmental deviations (e.g., language and learning impairments, serious problems in impulse control, antisocial). It is more than safe to assume that minority group children growing up in circumstances of poverty are represented in these figures of handicap far beyond their actual percentage of the population. Furthermore, these figures miss many cases which go undetected, including the more subtle cases of neurological dysfunction, mild mental retardation and untreated physical handicap, all of which also occur in a higher incidence in children of poverty. What does it tell us about ourselves, our decency as a society and about our future when we examine our behavior as a society towards these children?

In 1970 the Joint Commission on the Mental Health of Children submitted a detailed and massive report proclaiming that every infant must be guaranteed seven inalienable rights:

1. The right to be wanted
2. The right to be born healthy
3. The right to live in a healthy environment
4. The right to satisfaction of basic needs
5. The right to continuous loving care
6. The right to acquire the intellectual and emotional skills necessary to achieve individual aspirations and to cope effectively in our society
7. The right to receive care and treatment through facilities which are appropriate to their needs and which keep them as closely as possible within their natural setting.

Rights proclaimed are not the same as rights secured

Rights proclaimed, or even "guaranteed," are not the same as rights secured. I believe few would challenge that the above list does indeed define the basic rights of children because it represents the conditions essential for the fulfillment of the basic needs of children. Yet, upon examination of each, few would claim that we even reasonably approach adequate provisions for any one of them.

1. *The right to be wanted* is surely the least to which an infant is entitled. Yet we fail as a society to provide any reasonable alternative for the thousands of infants and children who are surrendered for adoption or abandoned by their parents. Adoptive homes are unavailable for most nonwhite children. Foster homes are almost equally unavailable for all, and in too many instances are unsatisfactory as well as child-care environments. The nurseries of nonprofit hospitals are accustomed to a population of infants left or abandoned by their mothers, who stay on as long-term residents, often for several months. This occurs more than 20 years after we have documented the destructive effects on personality and intellectual development of deprivation of early stimulation and consistent caretaking. With all our supposed commitment to early childhood we have done little or nothing to insure or provide that only parents who want children should have them or keep them, and that an effective network of infant and child care services is available for infants and children who are not adopted and cannot be placed in quality foster care.

Furthermore, there are millions of unwanted children born each year and allowed to remain, indeed forced to remain, with parents who did not and do not want them. Although some states have passed more liberal abortion laws, the large majority still force women to have babies they do not want, who given their choice would not continue their pregnancy, and so must almost inevitably attach feelings of resentment and rejection to that child. It is to my mind an affront to us all that our society, primarily in the form of legislative inaction and resistance, perpetuates legal restrictions on a matter which should be the private concern and decision of private individuals.

About 40 per 1,000 black, ghetto infants die

2. We speak of *the right to be born healthy*, yet we make little provision to insure truly adequate prenatal care. The availability of minimum nutrition, protection against maternal illness damaging to the fetus, and adequate medical care during the delivery and immediately post-partum are essential for healthy babies. Yet it is a fact that the often proclaimed richest nation on earth also has one of the worst infant-mortality rates of any developed nation. Even more damning is the sad truth that a white baby born to a suburban mother has as good a chance of survival as any in the world while the mortality rate for black, ghetto infants is two and a half times as high, about 400 per 1000. To quote Dr. Joseph Dancis, a New York pediatrician, in an article from a recent issue of *Today's Health*, "Infant mortality is a symptom of the state of a society."[1] To paraphrase Churchill, "Some state, some society." But, to look even further, would it be sufficient if all services necessary to reduce infant mortality to an absolute minimum were actually provided? The answer, I think, would be that this would represent only a necessary first step. Shouldn't we as a society not only provide but require that expectant mothers do what is necessary to protect the health of their babies. We will judge a child delinquent and impose legal penalties, including incarceration, if he fails to attend a school where he cannot learn because he is intellectually impaired perhaps as a result of poor maternal nutrition during the pregnancy. Yet we have no requirements of the mother who is neglectful of her nutrition and prenatal care during pregnancy, often out of ignorance, maybe as often out of indifference. When it comes to care during pregnancy, each mother is an independent entrepreneur. The cost of this freedom in terms of suffering to individual children and to our society as a whole is incalculable. The consequences of poor nutrition and inadequate prenatal care are recorded in terms of prematurity, neurological damage, intellectual deficit and high infant morbidity. We require that children be vaccinated, and have thereby eliminated smallpox, diphtheria, tetanus, polio, and can now see the end to measles, mumps and other illnesses. Why not some type of analogous system that requires of expectant mothers that they do what is necessary to protect the health of their babies?

Pregnant mother is independent entrepreneur

3. *The rights to live in a healthy environment, to have basic needs satisfied and to continuous loving care* are interrelated, and would seem to represent a sensible and minimal standard. Yet as a society we tolerate such conditions, for example, as substandard housing, the exploitation by both employers and parents of the children of migrant farm workers, the unavailability of good health care, and the overt physical abuse and more subtle psychological maiming of defenseless children. We can and should mandate and provide adequate housing, lead-free walls, rat-free rooms, heat in the winter, a bed for each child and easily accessible health care. But at the same time we also fail our children in potentially more pervasively destructive ways by what we fail to require of their parents. How do we go about guaranteeing to each child his right to consistent, protective, nurturing parental care? What is our responsibility, for example, to the first or fifth child born to a woman whose own mothering was inadequate to provide her a maternal capacity in her own right? What can we do, what should we do for the legions of children born into homes where they will be expected by age five or six to provide parental care to younger siblings or for those siblings who must look for their emotional nurturing to a limited mother or an already deprived and embittered older sibling. How do we protect children from being left to look after both themselves and one another only, as has been the sad outcome in countless instances, to have one of those children set a fire which destroys them all.

As recently publicized cases have informed us, we do not even protect a child from being suddenly removed from a good adoptive or foster home in which secure attachments have been formed, in order to restore him to the biological mother who for good reason or bad wants her child back. Let no one be misled into thinking that the rights and best interests of the child are a serious consideration in most such cases. It is the rights of the mother which are paramount. The child is considered as a piece of property. How can we as a society delegate such a monumental responsibility so exclusively to lawyers and judges, often political appointees, who have no preparation outside the law to rule on such issues?

In custody cases children are treated like property

OUR GREATEST FAILURE

Our lack of true commitment to the right of children to have consistent, warm nurturing care may be our greatest failure, inhumanity and shame as a society. While this is not an issue limited to the children of the poor, I have no doubt that the problem is greater in our deprived and underprivileged groups. We are not completely serious about our concern for children until as a society we are prepared to limit the right of any parents to possess children as property without establishing any standards or requirements of them. We pay huge sums of money to individual and corporate farm establishments not to cultivate their lands; could we not do as much to insure that children obtain adequate cultivation?

We condemn ourselves as a society and generations of our children to despair unless we are prepared to establish a machinery which, first, provides every possible opportunity for needy mothers to enhance and develop their maternal capacity through education, training, support and the supply of direct helping services; and second, places some limits on the number of children in families where it is clear that the child's rights cannot be secured in or by the family. We should have an effective system of child advocacy to supervise this and a coexisting child care system which provides viable alternatives for children removed from their natural parents. We need to establish a network of services offering a range from extended day-care to full-care residential settings staffed by trained child care personnel. Until we are prepared to make a sufficient moral and financial committment to these ends, we only console ourselves by an expression of empty concern for the welfare of those children who grow up outside the mainstream of our society.

One must ask how and by what mechanisms, as individuals and as a society, we have been able for so long to tolerate the poor treatment of underprivileged children. Charles Pinderhughes, a Boston psychiatrist, has extensively studied some of the psychological mechanisms that create and perpetuate racism. He describes a process of nonpathological (in the sense of individual pathology), group-related paranoia which serves the purpose of self-aggrandizement, self-enhancement and self-satisfaction by assigning to others any undesirable or renounced aspects of the self. If on the one hand racism is sustained by this process, so also do such mechanisms operate to isolate from our outrage and concern the endless sacrifice of minority group and economically deprived children.

4. Next we consider *the right to acquire the intellectual and emotional skills necessary to achieve individual aspirations and to cope effectively in our society.* The past few years have witnessed a veritable deluge of books, articles, essays and studies about the deficiencies and failures of our urban educational system in providing even the bare minimum essential skills of reading, writing and arithmetic, much less anything more sophisticated, to inner city children. It is a profoundly disturbing failure for which as yet no solution even seems reasonably close to being found. Most would agree that the problem does not begin when the child enters school. Inner-city children bring to the classroom a varying combination of developmental characteristics which on the whole represent liabilities so far as the extant formal academic process is concerned. These characteristics would include lags in language and cognitive development, a different style of impulse control, difficulties with attention span and frustration tolerance, and problems in both self-concept and feelings towards authority figures. The failure of the schools is only one aspect of the failure of our society to provide these children their basic rights. The Head Start Program was a needed beginning. Its results have so far been most promising in the area of improving general child health and disappointing in bringing about identifiable longer-term improvements in cognitive and language achievement.

THE CRISIS IN THE CLASSROOM

Another approach suggests that black children learn best, and perhaps only, from black teachers with whom they can make self-respecting, positive and corrective identifications. New York City has been the most publicized arena in which the battle over this proposition has been engaged, in the form of the struggle for community control. While there is merit to the issue, it is as unreasonable to expect that one group or color of teachers or one teaching method is going to be the answer to the problem as it is unfair and unrealistic to suggest that the problem was caused by a group of teachers of another color or their method. Attempts to answer whether it is the children or the teachers who are primarily responsible for creating the "blackboard jungle" have only further polarized the issues and intensified the conflicts. Whatever solutions are formulated to deal with the crisis in the classrooms will have to include efforts directed toward change in the earliest life experiences of these children. Indeed, there is reason to believe that a sufficiently massive and committed effort to guarantee to children their other basic rights would essentially insure that they would as a result be able to obtain as well their right to a good education.

5. The last right is that *of care and treatment for all children appropriate to their needs.* Simply reconsider that there are an estimated 10 million children in this country who have a sufficiently serious emotional or developmental disturbance to require some therapeutic intervention. Also remember that children belonging to minority groups and from circumstances of economic deprivation are over-represented in these numbers, and it is their needs which are particularly unmet and require more intensive services. Even if this were not the case, large areas of the country contain relatively economically advantaged population groups for whom almost no qualified professional help is readily available. To consider how far away we are from even beginning to be able to provide for the special needs of all these children is a nightmare exercise in program planning.

Yet this is not to suggest that the provision of adequate facilities and personnel is beyond the capacity of this country's material and educational resources. But to provide these would require the same degree of national concern and commitment as has been directed, for example, to the space program, the ABM, proposals for the SST, and of course dwarfing all else, the war in Vietnam. The current ordering of our national priorities does not suggest that the treatment needs of emotionally disturbed or mentally ill children rank very high.

Funding of services requires reordering of priorities

The act passed in 1965, providing for the establishment of community mental health centers, seemed a promising beginning. Yet, despite limited and localized examples of progress, sufficient funding has not been available to fulfill the promise. This insufficiency has been most notable in the area of funds for training the large numbers of qualified professionals and paraprofessionals who are needed to staff mental health facilities and provide for the growing needs for services demanded by an increasingly enlightened citizenry.

A reordering of priorities would indeed be required to fund treatment services for the vast majority of the population. To the average or even above-average income family the cost of obtaining appropriate treatment for emotional disturbance, learning disabilities and /or physical handicaps is simply prohibitive, even where available. Most families with children are young families, with years of financial responsibilities ahead of them. Most school systems are already strained beyond the ability of their resources to provide needed counseling, corrective and remedial services. Whether the treatment need is some form of psychotherapy, therapeutic education or institutional care, the need for governmentally supported or supplemented funding is increasingly apparent. And even if all the treatment resources needed were actually available, we would still only be treating the identified casualties and doing little in terms of stemming the flow at its source.

THE STORY OF DROWNING CHILDREN

There is the story of the group of men on a river bank who saw a child floating down the river and formed a chain to rescue him. As soon as they got him to shore, they saw two more in the water, and as soon as these were safe another four appeared, and then another six. One man started to leave the group, and the others shouted to him that there were still more children coming down the river to be saved from drowning. The man replied that they could continue to fish them out, but he was going upstream to find the fellow who was throwing them in. In regard to saving from drowning those already struggling in the water, and even more so in regard to preventing more from being thrown in, we have for many years effectively banished this problem from our serious concern and are only now beginning to acknowledge the insufficiency of our efforts. Perhaps our society has found it easier to tolerate injustice and inhumanity to children in terms of malnutrition, intellectual dulling, neurological damage, emotional neglect and wasted lives in part because the incidence of these damages is concentrated in the children of poverty and minority groups. But all our children who are deviant, different and have special needs still exist somewhere away from our collective concern, even when they are from more economically advantaged families. They are dealt with as abstractions, dehumanized and emotionally ostracized. We learn early the process of dealing with that which causes us discomfort or pain by locating it outside ourselves and identifying it as bad, evil or dangerous. Despite an intellectual awareness to the contrary, as acquired in later years, we often still act on the basis of the earlier processes. This frequently occurs in our institutionalized behavior as a society towards those who are different or deviant.

Can society continue to treat children as private possessions?

In an article in the *Saturday Review*,[2] Dr. Judd Marmor makes some comments about the problem of trying to change institutions and institutionalized behavior. He says, "The problems lie not in our individual psychopathologies, but rather in socially sanctioned egosyntonic group values. It is not the 'defectives' among us but we, the 'normal' ones, who constitute the problem." Later, he continues, "There is a deep resistance in most of us against changing of fundamental institutions in our society, because our basic personalities—our needs, expectations, our very language and perceptions—have been so profoundly shaped by those very institutions." Value systems are one aspect of our institutions and society, and we must reflect on the discrepancies between what has been called a child-centered society and the actual behavior of our society towards its children. Can our society continue to tolerate the treatment of children as entirely private possessions based on the traditional models of a free enterprise society, dominated as it is now by a technological capacity which many fear is rapidly moving beyond our control and is no longer in the service of human values? Large numbers of what has been referred to as our most valuable natural resource must receive an increasing degree of our communal, and not only our individualistic, concern. We cannot be more obsessively worried about the pollution of our air and water than we are about the pollution of young lives.

AN ANCIENT LESSON

We cannot continue to behave as if no problem really existed in regard to our concern and care for the rights of children. Society's attitudes towards those who are different or deviant is reflected very well in our literature and goes at least as far back as ancient Greece. In Sophocles' play, "Philoctetes," as the result of an accidental snake bite, Philoctetes develops an unsightly and odorous ulcer on his leg. The Greeks banish him to live alone on an island. The play deals with the process by which they must restore this outcast to society if they themselves are to survive. The people choose Achilles' adolescent son as their emissary; it is youth they must depend upon for their future.

A happy innocent childhood is one of the enduring myths of our culture. Its perpetuation may depend on our collective inclination as a society to banish from our concern the unsightly ulcer of unhappy, disturbed or deprived children. ▣

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TO THE TEACHER

The annotated bibliography which follows is offered as a useful reference list for the course of study. The items noted here are drawn from the larger bibliography utilized in the development of the curriculum document. The selected articles are suggested references for more detailed and in-depth study of various aspects of child maltreatment. The annotations that appear in quotation marks are provided by the publisher.

BOOKS, PAMPHLETS, AND JOURNALS

THE AMERICAN HUMANE ASSOCIATION, CHILDREN'S DIVISION-----is the disseminator of the 19 pamphlets on Child Maltreatment listed immediately below. Annotations are those provided by the association. Prices and ordering information may be found in Appendix D for those suggested for the Classroom Learning Center.

* A National Symposium on Child Abuse. 1972.

An interdisciplinary exploration of child abuse and sexual exploitation of children. Papers given at a national symposium which examined the intensity of the problem and discussed the legal, medical, and protective aspects of the problem. 72 pp.

* Child Abuse Legislation in the 1970's. Vincent DeFrancis and Carroll Lucht. rev. ed. 1974.

Report and analysis of current child abuse laws. Reflects changes; records status of laws in each state; calls attention to novel approaches; discusses problem areas; and challenges some concepts. Highlights selected language. A guideline for legislation. 208 pp.

* Due Process in Child Protective Proceedings. Thomas T. Becker. 1971

Discusses the implication of the mandate for due process as it applies to the neglect proceeding in juvenile court; defines the elements of due process, and interprets the precarious balance required to protect conflicting rights. 24 pp.

* Emotional Neglect of Children. Robert M. Mulford. 1958.

A penetrating analysis of the challenge to Child Protection posed by this difficult area of child neglect. 11 pp.

* Fourth National Symposium on Child Abuse. 1975.

Selected papers delivered at a national symposium which brought together panels of experts in areas of identification and protection of neglected, maltreated, and sexually abused children. Papers deal with multidisciplinary approaches, medical problems, and legal aspects in terms of invoking the authority of the courts. 92 pp.

* Suggested for Classroom Learning Center

* In the Interest of Children, A Century of Progress. Katherine B Oettinger, Rev. Arthur Morton, and Robert M. Mulford. n.d.

Review and assessment of problems and progress in child protection in the United States and England during the 20th Century. Discussion of needs, approaches, trends, and future goals. 28 pp.

* Let's Get Technical: The "Why and What" of Child Protective Services Vincent DeFrancis. n.d.

Explores special skills and their application through the use of a case history. 10 pp.

Neglecting Parents, A Study of Psychosocial Characteristics. Morton Cohen, Robert M. Mulford, and Elizabeth Philbrick. 1967.

Interpretation of the findings in a research project to identify the psychosocial characteristics of neglecting parents in almost 1,000 families. 28 pp.

* Plain Talk About Child Abuse. Herb Stoenner. 1972.

Six articles from The Denver Post which expose the myths and stereotypes popularly accepted about parents who neglect or abuse children. An interpretation for the general public of the nature and dimension of neglect and abuse, its causation and treatment. 24 pp.

* Protecting the Battered Child. Edgar Merrill, Irving Kaufman, Philip R. Dodge, and Arthur E. Schoepfer. 1962.

Report of a statewide study and analysis of child abuse cases, discussion of implications as viewed by experts in psychiatry, medicine, law, and social work. 30 pp.

** Protecting the Child Victim of Sex Crimes. Vincent DeFrancis. 1965.

Examines the impact to child victims of sex crimes and the process used to prosecute the offender; and explores approaches for protecting children from lasting emotional damage. 14 pp.

* Selected for Classroom Learning Center
** See Appendix F.

** Protecting the Child Victim of Sex Crimes Committed by Adults. Vincent DeFrancis. 1969.

The final report of an intensive 3-year study of sexual abuse of children. An in-depth analysis of the problem and its implications in terms of an enormous incidence, the severity of impact on the victim, the contribution of parents to the occurrence, and the responsibility for social services. Major findings remove the wraps from a hitherto ignored area of child neglect and abuse. 203 pp.

* Protective Services and Community Expectations. Vincent DeFrancis. n.d.

A discussion of community responsibility for providing protective services -- the legal frame of reference for physical and emotional neglect -- the problems involved in obtaining a legal finding of emotional neglect. 17 pp.

* Protective Services and Emotional Neglect. Max Wald. n.d.

A discussion of emotional neglect; description of skills and attitudes necessary to change destructive parental behavior; illustrations of techniques through case history. 20 pp.

* Second National Symposium on Child Abuse. 1972.

A group of national experts discuss multidisciplinary approaches for protecting victims of neglect and abuse. Roles and responsibilities of professionals involved in the process are interpreted and related to cooperative and coordinated services. 60 pp.

* Speaking out for Child Protection. Vincent DeFrancis. 1973. Highlights of testimony before U.S. Senate Subcommittee on Children and Youth. Strongly points to urgency of implementation of Child Protective Services. Gives perspective on progress in this specialized field. 28 pp.

* The Status of Child Protection. Vincent DeFrancis and Boyd Oviatt. 1971.

Discussion of the general failure to mount Child Protective programs of sufficient magnitude and competency to effectively treat the needs of neglected, abused children; questions are raised and directions for needed changes proposed. 28 pp.

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* Selected for Classroom Learning Center
** See Appendix F.

* Termination of Parental Rights. Vincent DeFrancis. 1971.

Explores the problem of termination of parental rights and the legal complications which surround the process. Basic data with respect to the rights of parents and children, and variations on the theme of how parental rights are affected, are presented and discussed. 20 pp.

Treating Parental Pathology. Elizabeth Philbrick. n.d.

A superb exposition of how authority in casework is employed in the process of treating the pathology of neglecting parents. 18 pp.

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* Blue Cross Association. Stress. Blue Print for Health Vol. 25:1, 1974 96pp.

A collection of articles on various aspects of stress in every day life. Attractively illustrated and easy reading.

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"The summary of a report by Dr. Bowlby to the World Health Organization, which collates expert world opinion on the subject and the issues arising from it, such as, the prevention of juvenile and adult delinquency, the problem of the 'unwanted child', the training of women for motherhood, and the best ways of supplying the needs of children deprived of their natural mothers."

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"A complete documentary history of public provision for American children, tracing the changing attitudes of the nation toward youth during the first two and one-half centuries of its history." Volume I: 1600-1865 (1970); Volume II: 1866-1932, parts one through six (1971); Volume II: 1866-1932, parts seven and eight (1971).

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For a review, see Unit II, p. 106.

Child Welfare League of America

The Neglected-Battered Child Syndrome, 1963. 46 pp.

A collection of articles dealing with this very important aspect of the child maltreatment syndrome.

Boardmen: "Who Insures the Child's Right to Health?"

Barbero, et al.: "Malidentification of Mother-Baby-Father Relationship"

Morris and Gould: "Role-Reversal: A Concept in Dealing with the Neglected-Battered Child Syndrome"

Costin, Lela B. Child Welfare: Policies and Practice. New York: McGraw-Hill, 1972.

Chapter 9 is entitled "Protecting Children from Neglect and Abuse." Intended for use as a text. Includes chapter discussion questions and bibliographical references.

D'Ambrosio, Richard. No Language But a Cry. New York: Doubleday and Company, 1970.

This is a true account of a victim of shocking child abuse. Written in a readable manner by the psychoanalyst who worked with Laura for several years, the book is recommended to the general reader as well as to students of psychology. The book reveals the use of techniques which brought about lasting personality change.

Day Care Council of New York, Inc. Children at Risk: The Growing Problem of Child Abuse. Day Care Council of New York, Inc., 1972.

"Describes what people can do about child abuse, including the doctor, the hospital, those legally responsible to report suspected abuse, and the social agency."

DeMause, Lloyd (ed.). The History of Childhood. New York: Harper Torchbooks, 1975.

A pioneer work which attempts the correlation of child-rearing practices with the course of events within specific periods in the history of nations.

Fontana, V. J. Somewhere a Child Is Crying. New York: MacMillan Publishing Co., Inc., 1973.

An in-depth research and account of the battered child syndrome in society, Suggestions are made for establishing preventive programs in schools, colleges, and social agencies.

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"...compiles findings from press and public-opinion surveys, from analysis of nearly 13,000 incidents..."

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Book contains chapters on the history and incidence of child abuse; the responsibility of physicians; the types of parents who abuse children; the help to be given by psychiatric and social workers; and the duty of law-enforcement agencies. The authors believe an integrated (medical, psychiatric, social, legal) approach is essential to solving the problem.

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The authors have a threefold purpose: 1) To suggest a treatment program which would prove helpful in either the large or small community, 2) To demonstrate that people with varying backgrounds and experiences can be helpful to the child and family, 3) To provide practical approaches to problems that arise when such help is provided.

Included are 17 articles covering four areas: 1) The Parents, 2) The Child, 3) The Setting: where can help best be given, 4) The Court and the Law: A Positive Role. Includes bibliography.

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A representative selection of literature, with a useful organization of ideas for teaching; includes a bibliography.

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A description, including case histories, of how early child-parent relationships can later affect adult life.

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"An inquiry into the importance of tactile experience in the development of the person."

*Montgomery County Public Schools. Proceedings: Project PROTECTION Child Abuse and Neglect Conference and Workshop, September 1974.

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*National Center for Comprehensive Emergency Services to Children. Comprehensive Emergency Services, A Program Description. Nashville, Tennessee: Nashville Urban Observatory, October 1974.

The description of a system designed to care for children in crisis: those abused and neglected by families; those abused and neglected by their community.

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"A worldwide study of the effects of parental acceptance and rejection."

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Helfer, Ray E. "Why Physicians Don't Get Involved in Child Abuse Cases"
Kemerman, S. B. "Cross-National Perspectives on Child Abuse and Neglect"
Davoren, E. "Foster Placement of Abused Children"

*Child Abuse and Neglect. The Problem and Its Management (OHD) 75-30073, 75-30074, 75-30075.

Vol. 1. An Overview of the Problem. 63pp.

A discussion of child maltreatment from many perspectives, including characteristics, effects and the problem of definition.

Vol. 2. The Roles and Responsibilities of Professionals. 80pp.

A discussion of the roles of professionals and agencies involved in treatment and case management.

Vol. 3. The Community Team. An Approach to Case Management and Prevention 208pp.

A description of community coordination for managing and preventing child abuse and neglect.

*The Diagnostic Process and Treatment Programs. Ray E. Helfer, M.D. (OHD) 75-69.

Suggestions for the diagnosis and treatment of the caretaker and the child. 44pp.

* Suggested for Classroom Learning Center
** See Appendix F.

*Profile of Neglect, A Survey of the State of Knowledge of Child Neglect. 1975. Norman A. Polansky, et al. (SRS) 76-23037.

A survey of the literature (status of the art), including an extensive bibliography. 58pp.

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Discussion of the problem with suggestions for a program of treatment. 25pp.

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APPENDICES

CONTENTS

APPENDIX

A Instructional and Performance Objectives by Unit
B Classroom Instructional Materials by Unit
C Definition of Terms by Unit
D Classroom Learning Center for Child Maltreatme
E Speakers and Information Resources
F Sexual Molestation of Children

APPENDIX A

Instructional and Performance Objectives by Unit

EVALUATION

In the Policies and Procedures Handbook, the revised MCPS Regulation 355-4, dated October 1, 1975, defines the instructional objective as "a general statement of what the student should attain"; the performance objective as "a specific statement of what the student should be able to do."

For each instructional objective in the course of study, sets of performance objectives have been designed with specific classroom activities and procedures developed for each set. The performance objectives are measurable and may be used as indicators of student attainment of the instructional objectives.

Each unit contains an evaluation section with sample assessment measures for each performance objective in the unit, and criteria for satisfactory attainment of each objective are itemized. For each unit, a class record form has been designed for the teacher to record student attainment of the performance objectives for that unit. For the student, an individual record form has been designed which includes the performance objectives for each of the six units. Sixty percent satisfactory attainment for the total number of performance objectives attempted by the student is suggested as the basis for course credit.

Each performance objective contains a statement of the behavior desired of the learner in demonstrating attainment of the objective. The key word which specifies the behavior is the verb. In order to prevent misunderstanding, both the teacher and the student should have a common understanding of the meaning of the key words. A Key Word List is therefore provided with a description of the behavior the learner should use in demonstrating attainment of the objective.

Teachers should make every effort to clarify the performance objectives for students. The teacher must have a thorough understanding of the intent of each performance objective in relation to the appropriate instructional objective and be able to communicate this intent to the learner. The learner must also know what is expected of him, so that it is essential also for the student to have a clear understanding of the behavior described in each performance objective.

KEY WORD LIST

for

Performance Objectives

CITE	- to quote information from an external source for the purpose of clarifying something (e.g., cite examples, data)
CLASSIFY	- to place into groups according to certain criteria
COMPARE	- to list the similarities and differences of things
DESCRIBE	- to state a verbal picture or /to/list the characteristics of a person, place, thing, or event
DISCRIMINATE AND DISTINGUISH	- to be able to differentiate one type from another -- similar to "classify"
EXPLAIN	- to describe the relationship between things and/or /to/present the reasons for an occurrence or relationship
IDENTIFY	- to select from among several choices the item(s) that meet(s) certain criteria
LIST	- to make a series of words or statements
PREDICT	- to state a possible conclusion before it occurs
RECOMMEND	- to present something as worthy of acceptance
STATE	- to make a declarative word phrase setting forth something

Definitions quoted from
Thomas Evaul. *Behavioral Objectives, Their Rationale and Development* (Merchantville, New Jersey: Curriculum and Evaluation Consultants) 1972.

UNIT I. THE PHENOMENON OF CHILD MALTREATMENT

Instructional Objective

THE STUDENT WILL BE ABLE TO COMPARE THE HISTORICAL AND CONTEMPORARY PHENOMENON OF CHILD MALTREATMENT IN SOCIETY.

Performance Objectives

1. DESCRIBE forms of child maltreatment in the past.
2. LIST possible reasons for child maltreatment in the past.
3. CITE medical and psychological evidence of child maltreatment in society today.
4. CITE statistical evidence of child maltreatment in society today.
5. CITE sociological evidence of child maltreatment in society today.
6. IDENTIFY dysfunctions within society which could result in a physically or psychologically damaged child.
7. IDENTIFY dysfunctions within the family which could result in a physically or psychologically damaged child.
8. IDENTIFY dysfunctions within the individual which could result in a physically or psychologically damaged child.

UNIT II. THE NATURE OF CHILD MALTREATMENT

Instructional Objective

THE STUDENT WILL BE ABLE TO DISTINGUISH THE NATURE OF CHILD MALTREATMENT FROM ACCEPTABLE OR USUAL CHILD REARING PRACTICES IN SOCIETY TODAY.

Performance Objectives

1. STATE the federal definition of child maltreatment.
2. IDENTIFY the caretaker.
3. DESCRIBE typical acts of physical and psychological abuse.

4. DESCRIBE typical acts of psychological abuse without physical abuse.
5. DESCRIBE typical acts of physical and psychological neglect.
6. DESCRIBE typical manifestations of physical abuse and neglect in the child.
7. DESCRIBE typical manifestations of psychological abuse and neglect in the child.
8. LIST characteristics of acceptable child-rearing practices today.
9. LIST characteristics of child maltreatment today.
10. COMPARE child maltreatment with acceptable child-rearing practices.

UNIT III. THE EPISODE OF CHILD MALTREATMENT

Instructional Objective

THE STUDENT WILL BE ABLE TO DESCRIBE THE COMPONENTS IN AN EPISODE OF CHILD MALTREATMENT.

Performance Objectives

1. LIST the components of the episode of child maltreatment.
2. EXPLAIN the role of the caretaker.
3. EXPLAIN the role of the child.
4. EXPLAIN the role of stress.
5. EXPLAIN the role of the passive partner.
6. EXPLAIN the role of the sibling on-looker(s).
7. IDENTIFY the potentially abusive or neglectful caretaker.
8. STATE the characteristics of the potentially abusive or neglectful caretaker.
9. IDENTIFY the potentially vulnerable child.

10. STATE the characteristics of the potentially vulnerable child.
11. DESCRIBE the potentially vulnerable child from the viewpoint of the caretaker.
12. STATE the meaning of the term "stress".
13. LIST the characteristics of stress.
14. CLASSIFY the kinds of stress.
15. DESCRIBE the origins of stress.

UNIT IV. THE PSYCHODYNAMICS OF CHILD MALTREATMENT

Instructional Objective

THE STUDENT WILL BE ABLE TO EXPLAIN THE PSYCHODYNAMIC DIMENSION OF CHILD MALTREATMENT.

Performance Objectives

1. STATE the meaning of the term psychodynamics.
2. STATE the meaning of the term interaction.
3. EXPLAIN psychodynamic interaction in relation to stress factors within society, the family, and the individual.
4. STATE the meaning of the term conscious (re)actions in relation to the caretaker.
5. STATE the meaning of the term unconscious (re)actions in relation to the caretaker.
6. DESCRIBE typical (re)actions of the caretaker to the child.
7. DISCRIMINATE conscious and unconscious (re)actions of the caretaker to the child.

8. EXPLAIN the relationship of stress to the conscious and unconscious (re)actions of the caretaker to the child.
9. STATE the meaning of the term conscious (re)actions in relation to the child.
10. STATE the meaning of the term unconscious (re)actions in relation to the child.
11. DESCRIBE typical reactions of the child to the caretaker.
12. DISCRIMINATE conscious and unconscious (re)actions of the child to the caretaker.
13. EXPLAIN the relationship of stress to the conscious and unconscious (re)actions of the child to the caretaker (i.e., to maltreatment).
14. EXPLAIN the relationship of nurturing experiences in infancy or childhood to the ability to nurture in later life.
15. EXPLAIN the relationship of conditioning toward violence in infancy or childhood to violent behavior in later life.
16. RECOMMEND ways to break the recurring cycle of child maltreatment from the standpoint of the child.
17. RECOMMEND ways to break the recurring cycle of child maltreatment from the standpoint of the caretaker.

UNIT V. THE PROBLEM OF CHILD MALTREATMENT

Instructional Objective One

THE STUDENT WILL BE ABLE TO IDENTIFY THE INDIVIDUAL AND SOCIETAL PROBLEM OF CHILD MALTREATMENT.

Performance Objectives

1. STATE the meaning of the term circumstantial child maltreatment.
2. DESCRIBE circumstantial child maltreatment in relation to dysfunctions within society.
3. DESCRIBE circumstantial child maltreatment in relation to dysfunctions within the family.
4. EXPLAIN the relationship of circumstantial child maltreatment to dysfunctions within the individual.
5. PREDICT the probability of circumstantial child maltreatment in relation to individual ability to cope with stress.
6. STATE the meaning of the term incidental child maltreatment.
7. DESCRIBE incidental child maltreatment in relation to dysfunctions within society.
8. DESCRIBE incidental child maltreatment in relation to dysfunctions within the family.
9. EXPLAIN the relationship of incidental child maltreatment to dysfunctions within the individual.
10. PREDICT the probability of incidental child maltreatment in relation to individual ability to cope with stress.
11. STATE the meaning of the term intentional child maltreatment.
12. DESCRIBE intentional child maltreatment in relation to dysfunctions within society.
13. DESCRIBE intentional child maltreatment in relation to dysfunctions within the family.

14. EXPLAIN the relationship of intentional child maltreatment to dysfunctions within the individual.
15. PREDICT the probability of intentional child maltreatment in relation to individual ability to cope with stress.

Instructional Objective Two

THE STUDENT WILL BE ABLE TO STATE THE PROVISIONS OF FEDERAL, STATE AND LOCAL CHILD MALTREATMENT LAW.

Performance Objectives

1. DESCRIBE briefly the chronology and extent of child maltreatment legislation in the U.S.
2. STATE the provisions of the federal Child Abuse Prevention Act of 1974.
3. STATE the provisions of the state law for a) abuse and b) neglect.
4. COMPARE the state law with the local law for a) abuse and b) neglect.
5. DESCRIBE the local reporting process for a) abuse and b) neglect.

UNIT VI. CHILD MALTREATMENT: HELP AND HOPE

Instructional Objective One

THE STUDENT WILL BE ABLE TO RECOMMEND RESPONSES TO THE PROBLEM OF CHILD MALTREATMENT WHICH PROVIDE HELP FOR BOTH THE CHILD AND THE CARETAKER.

Performance Objectives

1. IDENTIFY the kinds of responses which help the maltreated child.
2. DESCRIBE the kinds of help available to the maltreated child.

3. IDENTIFY the kinds of responses which help the caretaker.
4. DESCRIBE the kinds of help available to the caretaker.

Instructional Objective Two

THE STUDENT WILL BE ABLE TO RECOMMEND RESPONSES WHICH PROVIDE HOPE FOR PREVENTION OF CHILD MALTREATMENT IN SOCIETY.

Performance Objectives

1. IDENTIFY those in society who must respond to the problem of child maltreatment.
2. DESCRIBE the kinds of response which provide hope for prevention of child maltreatment in society.

APPENDIX B

Classroom Instructional Materials by Unit

CLASSROOM INSTRUCTIONAL MATERIAL

for

I. The Phenomenon of Child Maltreatment

SELECTED RESOURCES

1. Definition of Terms (I.1)
2. "Our Forebears Made Childhood a Nightmare" (I.2)
3. "Who Owns the Child?" (I.3)
4. Questions and Answers About Child Maltreatment (I.4)
5. "Child Abuse and Neglect Programs: A National Overview" (I.5)
6. Dysfunctions of Society, the Family, and the Individual (I.6)
7. "Child Abuse Reports Have Increased Since 1972" (I.7)
8. "Good Children' (Our Own), 'Bad Children' (Other People's), and the Horrible Work Ethic" (I.8)
9. "Is U.S. Becoming Less Child-Oriented?" (I.9)
10. "Imprisoning Our Children" (I.10)
11. "They've No Right To Destroy the Children" (I.11)
12. "Medical Care Lacking for Children of Poor" (I.12)
13. "Shipping Children South" (I.13)
14. "Child-Snatching" (I.14)
15. Classroom learning center for child maltreatment

AUDIOVISUAL MATERIAL

Overhead Transparencies

1. Table 1, Mershon Study Center
2. Age Profile 1974-75, Reports of Suspected Child Abuse, MCPS
3. Sex and Mean Age of Children Reported, MCPS
4. Age Profiles Compared, 1973-74 and 1974-75, MCPS

FILM

Children in Peril. Discusses causes of child abuse and programs developed for treatment of child abusers. S. T 22 min. color 1. Child abuse. EMC 362.7 5684 Media Concepts 1972.

Fragile, Handle with Care. A film of stark realism which tells of the death of an infant brought to the emergency ward time after time by its young parents before finally succumbing to maltreatment. The film delves into the reasons why parents abuse their children, and what happens to the children mentally and physically. It also looks into ways of preventing child abuse, the legal considerations involved, and the professional help that is available for children.

A KTAR TV film produced in cooperation with The Independent Order of Foresters 16mm color 26 min. Available on loan from Independent Order of Foresters, 10215 Reisterstown Road, Owings Mills, Maryland 21117.

CLASSROOM INSTRUCTIONAL MATERIALS

for

II. The Nature of Child Maltreatment

SELECTED RESOURCES

1. Definition of Terms (II.1)
2. Federal Definition of Child Maltreatment (II.2)
3. Identity of the Caretaker (II.3)
4. Typical Acts of Physical and Psychological Abuse (II.4)
5. Typical Acts of Psychological Abuse Without Physical Abuse Which May Result in Damage to the Child (II.5)
6. Typical Acts of Physical and Psychological Neglect Which May Result in Damage to the Child (II.6)
7. Characteristics of Child Maltreatment (II.7)
8. Typical Manifestations of Physical Abuse and Neglect in the Child (II.8)
9. Typical Manifestations of Psychological Abuse and Neglect in the Child (II.9)
10. "Signs of Trouble Preceded Death of Boy, 4" (II.10)
11. "Boy Spurned"; Boys Taken from Home After Beating"; "Infant, 2, Dies, Sitter Is Held"; "Child-beating Death Draws Man Ten Years" (II.11)
12. "Mother admits failure to feed son, who died a 'vegetable' of 8 pounds"; "2 Infants Found in Trash Can"; "Newborn Baby Is Found Left in Trashcan" (II.12)

13. "Beaten, they can't fight back" (II.13)
14. "Mother talks of horror, seeking aid" (II.14)
15. "Law broadened to aid battered" (II.15)
16. "Case History"; "Case History" (II.16)
17. "Don't Shake the Baby" (II.17)
18. "Counter-Culture Kids" (II.18)
19. "Child Care in America" (II.19)
20. Classroom learning center for child maltreatment

AUDIOVISUAL MATERIAL

Overhead Transparencies

5. Definition of Child Maltreatment
6. Identity of the Caretaker
7. Typical Acts of Physical and Psychological Abuse
8. Typical Acts of Psychological Abuse Without Physical Abuse
9. Typical Acts of Physical and Psychological Neglect
10. Characteristics of Child Maltreatment
11. Typical Manifestations of Physical Abuse and Neglect in the Child (a and b)
12. Typical Manifestations of Psychological Abuse and Neglect in the Child (a and b)

Slides (Series 1 through 10)

A color slide series of photographed examples of child maltreatment is in preparation.

Films

Cipher in the Snow This dramatization of psychological abuse is based on the true story of a boy who no one thought was important until his sudden death one snowy morning. The story on which the film was based won first-place award in the N.E.A. Teachers Writing Contest.
Brigham Young University 1973 16mm color 23 min. MCPS Film Library #6571

Growth Failure and Maternal Deprivation This film shows physical and mental retardation in young children which may often result from lack of parental attention, especially from the mother. Two children, one thirteen months old and one almost four years old are shown as examples of failure-to-thrive. The circumstances under which these children lived and those aspects of the mother-child relationship thought to be responsible for their failure to grow and develop normally are discussed.
McGraw Hill 1966 16mm black/white 28 min. MCPS Film Library #4218

CLASSROOM INSTRUCTIONAL MATERIALS

for

III. The Episode of Child Maltreatment

SELECTED RESOURCES

1. Definition of Terms (III.1a)
2. Interpretations of the Nurturing Experience (III.1b)
3. The Components (III.2)
4. The Potentially Abusive or Neglectful Caretaker (III.3)
5. The Criteria of Emotional Maturity (III.4)
6. Characteristics of the Potentially Vulnerable Child (III.5)
7. Typical On-Going Stress Factors (III.6)
8. Typical Stress Factor Immediately Prior to Maltreatment (III.7)
9. "How A Baby Learns to Love" (III.8)
10. "'Battered' Babies, Birth Without Violence" (III.9)
11. "How To Conquer Stress" (III.10)
12. "Child Care by Adolescent Parents" (III.11)
13. "Mom and Dad" (III.12)
14. "Holiday season filled with child abuse" (III.13)
15. Classroom learning center for child maltreatment

AUDIOVISUAL MATERIALS

Overhead Transparencies

13. The Episode of Child Maltreatment, The Components

14. The Potentially Abusive or Neglectful Caretaker (a and b)

15. Characteristics of the Potentially Vulnerable Child (a and b)

16. Typical On-Going Stress Factors (a, b, c)

17. Typical Stress Factors Immediately Prior to Maltreatment (a and b)

17c World of Abnormal Rearing

Films

Birth Without Violence A film depicting the birth delivery techniques of Dr. Frederick Leboyer, who has himself delivered more than 10,000 babies. Though considered radical by some, his supremely simple technique seemingly eases the birth trauma and helps the new human being to start life without pain, confusion and fear. Recommended for classroom use, where available.

Second Chance. The treatment of maternal deprivation syndrome is described in this film. A deprived 22-month-old child is seen through the period of hospitalization at the Chicago Children's Memorial Hospital. The profound effects of the lack of emotional care, the child's defensive reactions to maltreatment, and her improvement after therapy are illustrated and explored.
Children's Memorial Hospital 1974, color 12 min. Available through MCPS Film Library

CLASSROOM INSTRUCTIONAL MATERIALS

for

IV. The Psychodynamics of Child Maltreatment

SELECTED RESOURCES

1. Definition of Terms (IV.1)
2. Psychodynamic Interaction Illustrated, Doonesbury Cartoon Series (IV.2)
3. Typical Conscious and Unconscious (Re)Actions of the Caretaker to the Child (IV.3)
4. Typical Conscious and Unconscious (Re)Actions of the Child to the Caretaker, i.e., to Maltreatment (IV.4)
5. The Violence Cycle Illustrated, "World of Abnormal Rearing" (IV.5)
6. "Early Child Abuse and Adolescence, A Literature Review" (IV.6)
7. "Home Called More Violent Than Street" (IV.7)
8. Ann Landers' Column (IV.8)
9. "The Child-Abusing Parent: A Psychological Review" (IV.9)
10. "Violence in Our Society" (IV.10)
11. Selected Instructional Material from Units I, II, and III
12. Classroom learning center for child maltreatment

AUDIOVISUAL MATERIALS

Overhead Transparencies

18. Psychodynamic Interaction Illustrated, Doonesbury Cartoon Series 1 through 6
19. Typical Conscious and Unconscious (Re)Actions of the Caretaker to the Child (a, b, c)
20. Typical Conscious and Unconscious (Re)Actions of the Child to the Caretaker; i.e., to Maltreatment (a, b, c)
21. The Violence Cycle Illustrated, "World of Abnormal Rearing"

Films

War of the Eggs. A heart-rending incisive story of a young couple who quarrel and as a result, their young son begins to cry hysterically. The enraged young wife roughly pushes him down the stairs, badly injuring him. At the hospital a psychiatrist gently tries to help them. Painfully, husband and wife open to each other, accept responsibility for what they have done, and turn for help. Written by Michael Crichton, author of Andromeda Strain.

Paulist Productions 1974 16mm color 26½ min. MCPS Film Library

Rockabye Baby. A film which illustrates the effects of parental deprivation upon young animals and children. The importance of physical touching and body movement for normal social and emotional development are effectively dramatized through this film. It presents some of the techniques that psychologists use to measure mothering practices during the importnat infant years.

Time-Life Films, Inc. 1971 16mm color 20 min. MCPS Film Library #6095

CLASSROOM INSTRUCTIONAL MATERIALS

for

V. The Problem of Child Maltreatment

1. Definition of Terms (V.1)
2. "Child Abuse in the United States" (V.2)
3. "Child Abuse Legislation in the 1970's" (V.3)
4. "Child Abuse: Attempts to Solve the Problem by Reporting Laws" (V.4)
5. "The Child Abuse Prevention and Treatment Act of 1974"(V.5)
6. Child Abuse: Maryland State Child Maltreatment Law (V.6)
7. Child Neglect: Maryland State Child Maltreatment Law (V.7)
8. "Defining Emotional Neglect" (V.8)
9. "Preparing for a Neglect Proceeding: A Guide for the Social Worker" (V.9)
10. "The Problem of the Battered Child" (V.10)
11. "Child Abuse Syndrome: A Review" (V.11)
12. Instructional Materials for Units I, II, III, and IV
13. Classroom learning center for child maltreatment

CLASSROOM INSTRUCTIONAL MATERIALS

for

VI. Child Maltreatment: Help and Hope

1. Indicators of Child Maltreatment, Montgomery County Health Department (VI.1)
2. Child Abuse/Neglect Information, Montgomery County Health Department (VI.2)
3. "A Policy Statement on Child Abuse and Child Neglect"; "More About Project PROTECTION" (VI.3)
4. "Protect a Child Help a Parent, Our Community Responsibility" (VI.4)
5. Montgomery County Services for Maltreated Children and Their Families (VI.5)
6. "Even Parents Sometimes Lose Control" (VI.6)
7. "C.A.L.M.--A Timely Experiment in the Prevention of Child Abuse" (VI.7)
8. "Parental Stress Service--How It All Began" (VI.8)
9. "The Extended Family Center" (VI.9)
10. "Working With Abusive Parents, A Social Worker's View" (VI.10)
11. "Working With Abusive Parents, A Psychiatrist's View" (VI.11)
12. "Working With Abusive Parents, A Parent's View" (VI.12)
13. "Child Neglect: Reaching the Parent" (VI.13)
14. "Why Most Physicians Don't Want To Get Involved in Child Abuse Cases and What To Do About It" (VI.14)
15. "Understanding and Helping Child-Abusing Parents" (VI.15)
16. "Project PROTECTION: A School Program to Detect and Prevent Child Abuse and Neglect" (VI.16)

17. "Child Abuse: Detection and Prevention" (VI.17)
18. "Battered Children and Counselor Responsibility" (VI.18)
19. "Preventing Child Abuse" (VI.19)
20. "The Abused Parent of the Abused Child" (VI.20)
21. "The Rights of Children" (VI.21)
22. Instructional Materials for Units I, II, III, IV, and V
23. Classroom learning center for child maltreatment

Film

Don't Give Up On Me Produced for the Metropolitan Area Protective Service and the Illinois Department of Children and Family Services for use in case workers awareness training. This film uses real people in real situations to probe the reasons behind the child abuse pattern. A mother of two small children is in danger of having her daughter taken by the court, and the assigned social worker struggles to have the distraught mother come to grips with her problem.

Motorola Teleprograms, Inc. 1976 16mm color 28½ min.

Available from HELP Resource Project
1123 North Eutaw Street
Baltimore, Maryland 21201

APPENDIX C

Definition of Terms by Unit

TERMINOLOGY

The definition of terms forms an important part of the curriculum instruction. In the development of this curriculum, special effort has been made in the selection of terminology.

The effort here has been 1) to select the exact term to communicate the intended meaning; 2) to select only those terms found in a widely used dictionary readily available to students; and 3) to make certain that the definition of the term as found in the dictionary and the meaning of the term as used throughout the document are consistent.

The definitions are quoted (with one exception) from Webster's New Collegiate Dictionary (1974 edition); hence, some may be brief; some may be lengthy. Teachers should use the definitions as points of reference to synthesize the intent and meaning of the terms as used.

For each unit, the definitions are listed in the order of instructional use.

I. THE PHENOMENON OF CHILD MALTREATMENT

*DEFINITION OF TERMS (I.1)

1.	Phenomenon	n.	- 3.b. an exceptional, unusual, or abnormal person, thing, or occurence
2.	Maltreat Maltreatment	vt. n.	- to treat cruelly or roughly
3.	Syndrome	n	- a group of signs and symptoms that occur together and characterize a particular abnormality
4.	Radiological	adj.	- of or pertaining to the use of radiology (X-ray)
5.	Pathological Pathology	adj. n	- 2: altered or caused by disease 2 a: anatomic and physiologic deviations from the normal that constitute disease or characterize a particular disease
6.	Dysfunction	n	- impaired or abnormal functioning

* Webster's New Collegiate Dictionary. Springfield, Massachusetts: S & C Merriam Co.

THE NATURE OF CHILD MALTREATMENT

*DEFINITION OF TERMS (II.1)

1.	Physical	adj.	- 3:	of or relating to the body
2.	Psychological	adj.	- 1:	b: MENTAL
3.	Abuse	vt.	- 1:	to attack in words 4: to use so as to injure or damage
	Abuse	n.	- 4:	abusive language 5: physical maltreatment
4.	Neglect	vt.	- 1:	to give little attention or respect to: DISREGARD 2: to leave undone or unattended to especially through carelessness
5.	Damage	n.	- 1:	loss or harm resulting from injury to the person SYN: injury
6.	Injure	vt.	- 1a:	to inflict bodily harm b: to impair the soundness of
7.	Paramour	n.	-	an illicit lover

*Webster's New Collegiate Dictionary, 1974.

THE EPISODE OF CHILD MALTREATMENT

*DEFINITION OF TERMS (III.1a)

1.	Potential	adj.	- 1: existing in possibility: capable of development into actuality
2.	Vulnerable	adj.	- 1: capable of being physically wounded 2: open to attack or damage
3.	Stress	n.	- 1: constraining force or influence: as c: a physical, chemical, or emotional factor that causes bodily or mental tension d: a state resulting from stress
4.	Positive	adj.	- 6a: marked by or indicating acceptance, approval, or affirmation b: affirming the present of that sought or suspected to be present
5.	Negative	adj.	- 1a: marked by denial, prohibition, or refusal 2b: marked by features (as hostility or withdrawal) opposing constructive treatment or development
6.	Passive	adj.	- 3a: receiving or enduring without resistance: SUBMISSIVE
7.	Punitive	adj.	- 1: inflicting, involving, or aiming at punishment
8.	Authoritarian	adj.	- 1: relating to or favoring blind submission to authority
9.	Psychopathic personality	n.	- 1: an emotionally and behaviorally disordered state characterized by clear perception of reality except for the individual's social and moral obligations and often by the pursuit of immediate personal gratification in criminal acts, drug addiction, or sexual perversion

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* Webster's New Collegiate Dictionary, 1974.

10.	Psychoneurosis (Psychoneurotic) adj.	n.	- 1: a neurosis based on emotional conflict in which an impulse that has been blocked seeks expression in a disguised response or symptom
11.	Nurturance	n.	- affectionate care and attention
	Nurture	n.	- 1: TRAINING, UPBRINGING 3: the sum of the influence modifying the expression of the genetic potentialities of an organism. (See Interpretations of the Nurturing Experience (III.1b).

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* Webster's New Collegiate Dictionary, 1974.

THE EPISODE OF CHILD MALTREATMENT

INTERPRETATIONS OF THE NURTURING EXPERIENCE (III.1b)

".....the process in which an adult takes care of an infant; that is, a theoretically mature capable, self-sufficient person caring for a helpless, needy, dependent, immature individual...Mothering consists of feeding, holding, clothing, and cleaning the infant...along with the more subtle ingredients of tenderness, of awareness and consideration of the needs and desires of the infant and of appropriate emotional interaction with it."

".....the deep, sensitive, intuitive awareness of and response to the infant's condition and needs, as well as consideration of the infant's capacity to perform according to his age."

From "A Psychiatric Study of Parents Who Abuse Infants and Small Children" by Brandt F. Steele and Carl B. Pollock in _The Battered Child_, edited by Ray E. Helfer and C. Henry Kempe. Chicago: The University of Chicago Press (1974).

".....intimacy, empathy, trust and 'mothering', used in the generic sense of mother-father parenting. Intimacy as the positive outgrowth of a willingness to risk a sharing of onesself with another is seen as an expression of a bond of affection and closeness between 'parent and child'--Intimacy is the _emotional touching_ that leads to affectional fulfillment in an interpersonal relationship. It is the foundation stone to family harmony."

From "Parent Surrogate Roles: A Dynamic Concept in Understanding and Treating Abusive Parents" by Morris J. Paulson and Anne Chaleff in _Journal of Clinical Child Psychology_, Vol. II (3) Fall 1973.

THE PSYCHODYNAMICS OF CHILD MALTREATMENT

*Definition of Terms (IV.1)

1.	Physical	adj.	- 3a: of or relating to the body b: concerned or preoccupied with the body and its needs
2.	Psychological	adj.	- 2: directed toward the will or toward the mind
**3.	Dynamics	n.	- 2: the driving physical, moral, or intellectual forces of any area or the laws relating to them
4.	Psychodynamics Psychodynamic	n. adj.	- the psychology of mental or emotional forces or processes developing esp. in early childhood and their effects of behavior and mental states 2: explanation or interpretation (as of behavior or mental states) in terms of mental or emotional forces or processes 3: motivational forces acting esp. at the unconscious level
5.	Personality	n.	- 3a) the complex of characteristics that distinguishes an individual b(1): the totality of an individual's behavioral and emotional tendencies (2): the organization of the individual's distinguishing character traits, attitudes, or habits
6.	Interaction	n.	- a mutual or reciprocal action or influence
7.	Psychodynamic interaction	n.	- a (re)action in response to an influence (past or present), an event (past or present), or a person (past or present)
8.	Conscious reaction	n.	- reactions which are marked by thought, will, or design
9.	Unconscious reaction	n.	- reactions which are not known or perceived; unaware

* Webster's New Collegiate Dictionary, 1974

** Webster's Seventh Collegiate Dictionary, 1966

THE PROBLEM OF CHILD MALTREATMENT

*DEFINITION OF TERMS (V.1)

Circumstantial	adj.	- 1: belonging to, consisting in, or dependent upon circumstances
Incidental	adj.	- occurring merely by chance or without intention or calculation
Intentional	adj.	- 1: done by intention or design

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* Webster's New Collegiate Dictionary, 1974.

APPENDIX D

Classroom Learning Center for Child Maltreatment

CLASSROOM LEARNING CENTER FOR CHILD MALTREATMENT

In lieu of a suitable textbook, a classroom learning center for child maltreatment is suggested to supplement the classroom instruction. A variety of magazines, pamphlets, and article reprints for such a center may be obtained free or at low cost. Because effort, time, and money are involved in assembling the materials, teachers and students should develop a plan for use of the center which would insure availability of the materials for subsequent classes. All prices quoted were current as of spring, 1976.

Other resources appropriate to the study of child maltreatment which have been approved for classroom use may be added to the center.

- The American Humane Association, Children's Division, P. O. Box 1266, Denver, Colorado 80201. Pamphlets are ordered by number indicated and title.

8. Emotional Neglect of Children (1958) 10¢
9. Let's Get Technical: The Why and What of Child Protective Services (n.d.) 10¢
18. Protective Services and Community Expectations (n.d.) 15¢
20. Protective Services and Emotional Neglect (n.d.) 15¢
21. Protecting the Battered Child (1962) 35¢
34. In the Interest of Children, A Century of Progress (n.d.) 35¢
42. Child Abuse Legislation in the 1970's, rev. ed (1974) $2.50
43. The Status of Child Protection (1971) 35¢
44. Termination of Parental Rights (1971) 35¢
45. Due Process in Child Protective Proceedings (1971) 35¢
46. A National Symposium on Child Abuse (1972) $1.00
47. Plain Talk About Child Abuse (1972) 35¢
48. Second National Symposium on Child Abuse (1972) $1.00
49. Speaking Out for Child Protection (1973) 50¢
50. Fourth National Symposium on Child Abuse (1975) $1.00

- American Psychological Association. Journal of Clinical Child Psychology. 2(Fall 1973). $2.50 Suite 208 Meramec Bldg., 111 S. Meramec Avenue, St. Louis, Missouri 63105

- Blue Cross Association. Stress. Blue Print for Health 25(1974) Free. 840 North Lake Shore Drive, Chicago, Illinois 60611

- Irwin, Theodore. To Combat Child Abuse and Neglect. Public Affairs Pamphlet 381 Park Avenue, South, New York 10016 35¢
- Maryland, State of. Department of Employment and Social Services, Social Services Administration. Incidents of Suspected Child Abuse in Maryland, 1972. Free.
- Maryland, State of. Department of Employment and Social Services, Social Services Administration. Incidents of Suspected Child Abuse in Maryland, 1973. Free.
- Montgomery County Public Schools. Proceedings: Project PROTECTION Child Abuse and Neglect Conference and Workshop, September 1974. Free.
- Montgomery County Services for Maltreated Children and Their Families. Project PROTECTION November 3, 1975.
- Mutch, David. "Rescuing Abused and Neglected Children." A series of five articles. Christian Science Monitor October 21-25, 1974.
- National Center for Comprehensive Emergency Services to Children. Comprehensive Emergency Services, A Program Description. Nashville: Nashville Urban Observatory, October 1974. Free.
- U. S. Congress, Library of Congress, Congressional Research Service. Child Abuse. Jean Yavis Jones, Education and Public Welfare Division. HV 741 U.S. C 75-97 ED. Free.
- U. S. Department of Health, Education and Welfare.

  Available from the Supt. of Documents, U. S. Government Printing Office, Washington, D. C. 20402:

  - Profile of Neglect, A Survey of the State of Knowledge of Child Neglect (SRS) 76-23037 $1.20

- Report of the U.S. Department of Health, Education, and Welfare to the President and Congress of the United States on the Implementation of Public Law 93-247, The Child Abuse Prevention and Treatment Act. August 1975.
- Child Abuse and Neglect: The Problem and Its Management. Vol 1 An Overview of the Problem (OHD) 75-30073 $1.50; Vol 2 The Roles and Responsibilities of Professionals (OHD) 75-30074 $1.90; Vol 3 The Community Team, An Approach to Case Management and Prevention (OHD) 75-30075 $2.60
- The Diagnostic Process and Treatment Programs by Ray E. Helfer (OHD) 75-69.
- Working with Abusive Parents, From a Psychiatric Point of View by Brandt F. Steele (OHD) 75-70.

APPENDIX E

Speakers and Information Resources

SPEAKERS AND INFORMATION RESOURCES

Montgomery County

Community Coordinated Child Care Council
301 E. Jefferson Street
Rockville, Maryland 20850
279-1773

Department of Social Services
Protective Service Unit
5630 Fishers Lane
Rockville, Maryland 20852
279-1758

Montgomery County Child Protection Team
301 E. Jefferson Street
Rockville, Maryland 20850
279-1512

Office of Human Resources
Child Protection Services
301 E. Jefferson Street
Rockville, Maryland 20850
279-1512

Maryland

HELP Resource Council
1123 North Eutaw Street
Room 103
Baltimore, Maryland 21201
301-383-3306

Montgomery County Legislative Delegation
County Office Building
Rockville, Maryland 20850
279-1224

Prince George's County Legislative Delegation
County Office Building
4811 Riverdale Road
Riverdale, Maryland 20781

Metro Area

Children's Hospital
National Medical Center
2125 13th Street, NW
Washington, D. C. 20009

Georgetown University Speakers Bureau
3800 Reservoir Road, NW
Washington, D. C. 20007
625-4151

National

American Humane Association
Children's Division
P. O. Box 1266
Denver, Colorado 80201

Child Welfare League of America, Inc.
67 Irving Place
New York, New York 10003

National Center for Child Abuse and Neglect
Office of Child Development
P. O. Box 1182
Washington, D. C. 20013

National Center for the Prevention and Treatment of Child Abuse and Neglect
1205 Oneida
Denver, Colorado 46926

U. S. Department of Health, Education and Welfare
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20852

U. S. Senate, Subcommittee on Children and Youth
443 Old Senate Office Building
Washington, D. C. 20510

APPENDIX F

Sexual Molestation of Children

TO THE TEACHER

Because the psychodynamics are different and more complex, sexual molestation of children is not included in this curriculum. Sexual abuse, however, is a part of the definition of child maltreatment according to State law. (See p.285.) Teachers should therefore be informed. Two references are included here for informational purposes. Teachers are urged to refer to the items noted in the Selected Articles and the Annotated Bibliography for more in-depth understanding of the topic.

SEXUAL MOLESTATION OF CHILDREN

The Last Frontier in Child Abuse

Children Today 5(May-June 1975)

by Suzanne M. Sgroi

Any member of the "helping professions" who is searching for an effective method to make himself unpopular with his peer group can probably achieve that goal by frequent involvement in cases such as those described above. The professional who becomes sufficiently concerned and knowledgeable about sexual abuse of children to be consistently alert to the possibility that sexual molestation *may* have occurred will often face a spectrum of reactions from his colleagues that range from incredulity to frank hostility. For although the pioneering efforts of many distinguished professionals and dedicated lay people over the past decade have made child abuse a national issue, the problem of sexual molestation of children remains a taboo topic in many areas.

This is not to argue that the problem of child abuse has been "solved" anywhere in the United States. It is, however, fair to assert that sexual abuse of children is the last remaining component of the maltreatment syndrome in children that has yet to be faced head-on. In medical parlance, child molestation is the least popular diagnosis. In the vernacular, it is not nearly so "in" a topic as child battering or neglect. Combatting these forms of maltreatment is publicly applauded and encouraged. But somehow, protecting children against sex crimes has received far less community sanction. It seems to be "too dirty," "too Freudian" or perhaps "too close to home." Thus one who becomes concerned with this particular aspect of child protection must be prepared to cope with a very high degree of resistance, innuendo and even harassment from some, as well as indifference from others. The pressure from one's peer group as well as the community to ignore, minimize or cover up the situation may be extreme.

Incidence of Molestation

No one knows the true incidence of child molestation in the United States today. Vincent DeFrancis, director of the Children's Division of the American Humane Association, conducted a comprehensive 3-year study of child molestation in New York City that was reported in 1969.[1] His estimate of approximately 3,000 cases each year in New York City alone is probably conservative. Considering the widespread reluctance to recognize and report this condition, it must be assumed that the reported incidents represent a small fraction of the cases.

Nevertheless, the reporting of suspected sexual abuse of children is encompassed in the child abuse reporting statutes of many states. Recent strengthening of these statutes and the establishment of child abuse hotlines has markedly increased the reporting of all forms of child maltreatment. In Connecticut, for example, passage of an expanded child abuse reporting law (P.A. 73-205, effective October 1, 1973), which involves a $500 fine for mandated reporters who fail to report suspected child abuse, resulted in 1,957 reported cases in fiscal year 1974—an increase of nearly 200 percent over the preceding fiscal year. A breakdown of the total by reporting source is shown in Table I below.

The opening of the Care-Line, a 24-hour statewide toll-free child abuse prevention and information line, probably had a significant impact since it facilitated the reporting process for many professionals and private citizens who called to express concern about children. The Connecticut Child Welfare Association (CCWA), a private statewide citizens' organization which operates the Care-Line, has also conducted a continuing education effort aimed at both the general public and the professional groups who have been required to report cases of suspected child abuse since 1971. Connecticut's Municipal Police Training Council has cooperated by incorporating lectures on child abuse detection and reporting

TABLE 1

Total Number of Children Reported As Suspected Abused in Connecticut*

	Physicians	Hospitals	Police	Schools	Social Workers	CCWA Care-Line	Others	Total
F.Y. 1973 number	37	205	107	122	65	**	133	669
percent	5.5%	30.6%	16%	18.2%	9.8%	**	19.9%	100%
F.Y. 1974 number	98	396	456	401	327	104	175	1957
percent	5%	20.3%	23.3%	20.5%	16.7%	5.3%	8.9%	100%

* *Connecticut State Welfare Department statistics.*

** *A statewide toll-free child abuse hotline has been operated by the Connecticut Child Welfare Association, a private citizen's organization, since October 1, 1973.*

Case No. 1: A Florida newspaper tersely reported to its readers early in 1975 that the city's youngest rape victim to date was only two months old at the time of the sexual assault. No other comment was offered.

Case No. 2: Two and one-half-year-old Jerry was admitted to the hospital because he cried when he passed urine and his mother noticed a discharge of pus from his penis. When his problem proved to be an acute gonorrhea infection, public health authorities investigated his home and found that Jerry's mother, father and an older sibling were all infected. His doctor was persuaded that a non-sexual mode of transmission had occurred because the family members were reported to share the same bed frequently. All of the family members were treated for infection simultaneously, Jerry's parents were counseled to avoid allowing their children to sleep in "contaminated sheets," and the case was closed.

An epilogue, however, was written several months later when an alert nursery school teacher noted that Judy, Jerry's 4-year-old sister, consistently refused to take her turn riding a rocking horse during playtime. When asked why, she replied "It hurts." A careful examination by the school's pediatrician that same day revealed the presence of sperm in Judy's vagina. An immediate joint police-Protective Services investigation of the family revealed that Jerry's and Judy's father had a long history of previous incidents of child-molesting although none had ever been proved. Their mother admitted she was aware that both children had been sexually assaulted by their father on numerous occasions.

Case No. 3: Stephanie, at age 17 months, was brought to a hospital emergency room by her mother who had noticed blood in the baby's diaper after she returned home from work. On examination, the child was found to have a small anal fissure that bled freely when touched. There was no previous history of abnormality or trauma and the mother was reassured that the fissure could be easily corrected surgically if *it* did not heal by itself. Several weeks later, Stephanie was found dead in her crib—a victim of asphyxiation. An autopsy revealed the presence of semen in her mouth and throat. When apprehended, the babysitter, a 19-year-old boy, freely admitted to sexual abuse of the child but protested "I didn't mean to kill her!"

Suzanne M. Sgroi, M.D., is an associate physician, Department of Ambulatory and Community Medicine, Mt. Sinai Hospital, Hartford, Connecticut and health director, Connecticut Child Welfare Association, Inc. She will be serving as project internist for the Connecticut Child Abuse and Neglect Demonstration Center in Hartford.

into their mandatory training program for all newly-hired police officers in 166 of the state's 169 towns. These child abuse training sessions were initiated in 1972 as part of the CCWA Child Advocacy Project and have been conducted by Association staff at 6-week intervals ever since. In October 1973 the two groups jointly sponsored and taught three one-day seminars on child abuse which were attended by higher ranking police officers from all over the state. It is therefore not surprising that the percentage of reports of suspected child abuse by police officers increased markedly in F.Y 1974, while reports by hospitals decreased proportionately and those by private physicians remained at the same low level—five percent.

It is noteworthy that during this same reporting period, the total number of reports of suspected sexual abuse of children in Connecticut increased, while the proportion of such reports to total child abuse reporting statistics declined slightly. Table 2, below, shows a breakdown of sexual abuse by type of report.

In fiscal years 1973 and 1974 in Connecticut, the relationship of the perpetrator to the child in all cases of suspected abuse was that of a parent or a parent-substitute in 80 percent of the cases. This complements DeFrancis' finding that parents were involved in the sexual molestation of children in 72 percent of the cases studied—either by perpetration of the offense (25 percent) or else by acts of omission or commission.[2] The most frequently named perpetrator in cases of sexual abuse is the father or a male relative or boyfriend—virtually always someone who has ready access to the child in his or her home. Ages of victims may range from early infancy (one to two months) all the way to 17 or 18 years.

Recognizing Sexual Abuse

Why is sexual molestation of children the last frontier in child abuse? And what are the major obstacles to identifying the sexually abused child?

In practical terms, the answers are lack of recognition of the phenomenon, failure to obtain adequate medical corroboration of the event, and reluctance to report. If one accepts the premise that it is impossible to protect the child victim of sexual molestation unless we know that he exists, these obstacles take on major importance. Each is rooted in ignorance and taboo and must be considered accordingly.

Recognition of sexual molestation in a child is entirely dependent on the individual's inherent willingness to entertain the possibility that the condition may exist. Unfortunately, willingness to consider the diagnosis of suspected child sexual molestation frequently seems to vary in inverse proportion to the individual's level of training. That is, the more advanced the training of some, the less willing they are to suspect molestation.

The lack of preparation and willingness of many physicians to assist patients with sexual problems in general has often been noted. When the patient is a child, these deficiencies are extremely serious.

TABLE 2

Reports of Suspected Sexual Abuse of Children in Connecticut *

	Incest & Rape	Sexual Molestation	Venereal Disease	Total Sexual Abuse	Total cases of Suspected Child Abuse	% Sexual Abuse
F.Y. 1973	19	57	**	76	669	11.4%
F.Y. 1974	47	108	17	172	1957	8.8%

* *Connecticut State Welfare Department statistics*

** *Acquired venereal disease in children under age 13 years did not become reportable as suspected child abuse until fiscal year 1974 (October 1, 1973).*

If the victim of alleged sexual assault is a child, a complete physical examination with careful attention to any other signs of physical abuse or neglect must accompany the routinized perineal examination and laboratory tests. The examination is not complete unless the child is carefully scrutinized for evidence of oral and/or anal penetration as well as genital sexual contact. This includes inspection for trauma as well as laboratory tests for the presence of semen and venereal disease.

Unfortunately, all too few health professionals are trained to look for or to recognize the signs of rectal and urogenital gonorrhea infections in young children. This not only requires a high index of suspicion but again an inherent willingness to entertain the diagnosis of acquired venereal disease in a child. With the exception of congenital syphilis and gonococcal eye infection in newborns, the presence of a gonorrhea or syphilis infection in a child makes it imperative that sexual molestation be suspected unless or until it is ruled out by a careful joint medical and protective services investigation. The U.S. Public Health Service, which operates the National Communicable Disease Center in Atlanta, Georgia, has recently cautioned that "with gonococcal infection in children, the possibility of child abuse must be considered!" [3]

Medical Corroboration of Abuse

The next major obstacle to identifying and helping the child victim of sexual abuse is failure to obtain immediate medical corroboration of the assault. This occurs most frequently on the grounds that physical examination of the child will aggravate and intensify the psychological trauma that may already have been experienced. However, this attitude has little basis in fact and may be detrimental in the extreme to the future protection of the child. A gentle and thorough examination, as outlined above, conducted by a knowledgeable examiner, will be well tolerated by most children. The experience not only can be non-threatening but it may also be reassuring

Recognition of sexual molestation in a child is entirely dependent on the individual's inherent willingness to entertain the possibility that the condition may exist.

and welcomed by a child victim who is old enough to worry that he or she may have been harmed by the assault. For example, the examiner may find numerous opportunities to assure the child that all is well, that no harm has occurred or else that any injury incurred can be alleviated.

It is well to avoid repeated questioning of the child about circumstances relating to the incident of sexual abuse at any time. Such questioning is particularly to be avoided during the physical examination. Since repeated examinations may indeed be traumatic, the first should be comprehensive enough to preclude the necessity for further examinations if the child's condition does not require them.

Preventing a recurrence of sexual abuse should be a twin therapeutic goal along with preventing and alleviating any psychological damage incurred by the sexually molested child. Each of these goals should have equal priority. The therapist who counsels against a comprehensive and compassionate examination of the child in a case of suspected sexual assault (including, of course, a physical examination) effectively circumvents an adequate Protective Services investigation of the case. It is a known fact that judicial proceedings against child molesters virtually require that medical evidence of sexual assault be presented. Without such evidence, it is practically impossible to protect the child against repeated sexual assault by preventing or monitoring access of the child-molesting adult to the victim, especially in the intra-family situation.

The frequently recommended alternative of removing the child temporarily or permanently from the "at risk" situation by transferring custody from his or her parents to the state has the disadvantage of risking serious damage to the child by the act of premature separation from the "psychological parent." Thus the totality of risks must be carefully weighed in selecting what the authors of *Beyond the Best Interest of the Child* term "the least detrimental alternative."[4]

Regardless of the consequences, it would be unusual in any state for a child to be removed permanently from his parents to protect him from sexual abuse if corroborating medical evidence were not presented to verify that sexual molestation of that child had already occurred within the family. To put it another way, the future protection of a child victim of sexual assault is virtually impossible without a carefully recorded examination by a knowledgeable physician.

Reporting Sexual Abuse

Failure to report to the statutory authority is the last major obstacle to identifying the sexually abused child. Sexual abuse of a minor is a reportable condition in every state in the United States. Such a report is the triggering mechanism for a Protective Services investigation of the child and his family—thereby providing a conduit for professional help and community resources to strengthen and improve the home situation or, occasionally, to remove a child from an untenably dangerous environment. Nevertheless, sexual abuse of children is grossly underreported.

It is unconscionable that any member of the "helping professions" would violate the law as well as withhold potential help from the child victim by failure to report suspected sexual abuse. In most areas it is particularly inappropriate to withhold reports to the statutory authority on the grounds that more effective therapy for delicate internal family matters can be provided surreptitiously by a private agency or private practitioner. Since the success of the private agency's efforts to monitor the home situation for indications of recurrent abuse is directly dependent upon the family's voluntary compliance (which may cease at any time), such reasoning is fallacious. A far more appropriate course for the private help source who discovers the abuse is to report immediately and request to "service" the case in cooperation with the statutory authority. In most cases, cooperation with the frequently superior resources of the private source of help will be eagerly welcomed by the public agency. The result: a higher level of service available to the family as well as increased protection for the child.

For too long health professionals have skirted the issue of reporting suspected sexual molestation when an unmistakable diagnosis of acquired venereal disease has been made in a child. We have been content to do contact investigation within the family circle and to treat other family members—parents, aunts and uncles, older siblings, etc.—for venereal disease without asking why or how a 6-year-old boy acquired a gonorrheal urethritis or a 3-year-old girl contracted pelvic infection with gonococci. Because of reluctance to entertain the possibility of sexual molestation of a child by an adult, we have often postulated modes of transmission of venereal disease to children within the family circle that were long ago discarded in relation to adults, such as the possibility of transmission via clothing, towels and bedsheets. In view of what we know about the epidemiology of gonorrhea and syphilis in adults, it is absurd to cling to an erroneous double standard when we deal with acquired venereal disease in children. We must assume that these children have had some type of sexual contact, most probably with an adult, and investigate accordingly.

In the past, there has been some concern by public health authorities about violation of confidentiality by

(Continued on page 44)

Sexual Molestation—*(Continued from page 21)*

sharing a report of venereal disease in a child with the statutory agency mandated to investigate suspected child abuse. Connecticut is the first state in the United States to clarify this issue in its child abuse reporting statute. According to the Connecticut law, all reports of acquired venereal disease in children under 13 years of age must be reported to Protective Services as well as to the State Health Department. In this way a simultaneous Protective Services investigation of the family may, if necessary, initiate steps to protect the child from further sexual molestation while public health authorities do contact investigation and treatment to prevent further transmission of the disease.

Identifying Abused Children

Since we cannot help the sexually abused child and his family unless we know they exist, how then can the major obstacles to identification detailed in this article be overcome? The key role of the physician in obtaining adequate medical corroboration of sexual abuse has not been minimized. Nevertheless, any concerned individual, especially when professionally involved with some aspect of child care, can do much to enhance recognition and reporting of this phenomenon.

First, since this is a phenomenon that thrives and proliferates in darkness, we need to open windows and doors and promote open public discussion of the topic. Increased public awareness is best stimulated by people who care enough to snatch every opportunity to arouse society's consciousness of the child victim of sexual abuse. Only then will the public sanction so vital to identifying and assisting these children be forthcoming.

Instead of wasting time during a crisis situation in helpless frustration with medical personnel who are uncooperative or unknowledgeable in this area, those who are concerned should identify and establish a relationship with reliable sources of medical help in advance. Knowledgeable and receptive physicians and health professionals in the community should be sought out so that ways to improve medical services to child victims of sexual assault can be jointly explored. Emergency rooms or private practitioners who do the most effective and sensitive job should be identified, encouraged and patronized. The services of new demonstration programs in this area should also be identified and sought.

Connecticut has recently received funding from the Children's Bureau, OCD to establish a Child Abuse and Neglect Demonstration Center that will enable a multidisciplinary consortium of agencies to work cooperatively toward diagnosis and treatment of families where child abuse, neglect or sexual molestation is a danger. One of the center's charges will be to delineate a workable range of effective services for child protection. As a last resort, it may be necessary to utilize legal and judicial means to identify and enforce the basic minimum standard of medical services that the sexually abused child is entitled to receive.

Lastly, it behooves every professional who deals with children to be aware that sexual molestation exists, to recognize danger signals—especially in high-risk children—and to be knowledgeable about his or her state's reporting laws and sources of help. Sexual abuse of children is certainly not the problem of any single profession or segment of society. A strong united effort is required to push back the last frontier in child abuse and assist the sexually molested child. ■

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[1] *DeFrancis, Vincent,* "Protecting the Child Victim of Sex Crimes Committed by Adults," *Children's Division, American Humane Association, Denver, 1969.*

[2] *Ibid.*

[3] *"Gonorrhea: The Latest Word,"* Emergency Medicine, *Vol. 7, No. 2, February 1975, pp. 132-138.*

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A Series of Three Articles on:

April 14, 15, and 16, 1975

Battered Children: Innocent Victims of Recession's Stresses

By Michael Satchell
Washington Star Staff Writer

Cases increase with parents' frustrations

The signs, coast to coast, are ominous.

Case-hardened social workers in recession-wracked Detroit are stunned when five "very severe" cases of child battering, one of them fatal, occur in the same vestpocket neighborhood on the Lower East Side in less than a month.

First of three articles

In Los Angeles, the number of children under 10 murdered by their parents or guardians suddenly doubles during the first two months of 1975 over the same period last year, and worried police officials fear the trend will continue. The expected legacy: 50 child abuse deaths in that city this year, double that of 1974.

An Atlanta real estate salesman, depressed when his business suddenly plummets because of the housing squeeze, beats his 5-year-old daughter and puts her in hospital . . . and a New Orleans man, newly laid off from his job, breaks the news to his distraught wife and then bashes his baby's head against a wall until the infant loses conciousness

Last week, a D.C. man was charged with killing his daughter.The two month old infant's badly beaten body was found by her mother in a bassinette in the family's Northeast Washington home. The father is unemployed.

All over the country, reported cases of child abuse and neglect are rising sharply and puzzled officials, searching for reasons why, are beginning to focus on the current economic condition as the culprit behind the upsurge. Children, in a sense, are becoming the innocent victims of the recession.

THE FORMULA, as the experts see it, is this. As unemployment soars, inflation rises and the economic noose tightens, hard-pressed families are placed under greater stress, and those with the potential for child neglect and abuse vent their frustrations by lashing out at their children.

Alarmed by the trend, the National Center for Child Abuse of the U.S. Department of Health, Education and Welfare has begun a crash study of the problem, hoping to save young lives and slow down the grim procession of battered young bodies into the nation's emergency rooms.

"We are making very strenuous efforts to increase training of professional workers in this field, to increase public awareness of the problem and to gather data about these incidents," said Frank Ferro, acting associate chief of the Children's Bureau at the HEW agency. "I have no doubt that there is a relationship between unemployment and the economic crisis and the increased incidence of child abuse and neglect. The question is, how do you deal with it?"

Child abuse and neglect is one of those social problems that is so pervasive and deep-rooted that no agency, public or private, has been able to come to grips with it. There are no reliable nationwide totals of reported cases, although the Children's Division of the American Humane Association headquartered in Denver is putting together what should be the first nationwide analysis of child abuse.

Scores of thousands of cases are investigated by authorities each year, but officials feel they only hint at the true extent of the problem, for child abuse remains one of the great hidden — and thus unreported — crimes. HEW's Ferro likened the difficulty of accurately measuring the national incidence of child abuse to "trying to grab a handful of mercury.

"About all we can offer is the conventional wisdom," he said. "For every physical abuse case, there are anywhere from one to three neglect cases. For every abuse or neglect case reported, two or three go unreported, which means we are seeing only the tip of the iceberg.

"STUDIES DONE for us have estimated the child abuse and neglect rate at somewhere between 7.6 cases and 13.4 cases per thousand children. About the only firm thing we can say is that we know that two children die each day in America from battering, and even that figure may be low because the cause often is hidden."

Dr. Nina Scribanu, assistant professor of pediatrics at Georgetown University, observed: "This problem crosses economic lines, you find it in the nicest neighborhoods, and it happens as much in middle or upper class homes as in lower social levels. But the better-off families are better able to hide it, they take their children to private physicians for example, who often don't recognize cases of abuse. And even if they do, they don't report them for investigation."

Just as police departments around the country have tagged sharp increases in economic crimes such as burglary, theft and bad check writing to the recession, those monitoring child abuse cases are coming slowly to the realization that the sharp increase in caseloads is closely related to the recession, although there is no way to match unemployment statistics with percentage increases in child abuse.

"The difficulty is determining whether the rise is due to a higher incidence of abuse, or to better reporting," explained Ferro. "For example, in Florida in 1970-71, there were just 17 reported cases of abuse. They conducted a massive public education campaign and the next year, there were over 19,000 cases reported, with 60 percent of them valid. Now they are up to 30,000 cases a year. Florida is a perfect example of how notoriously underreported this crime is."

In Wayne County, Mich. where Detroit is located, Sam Manzo, the supervisor of children and family services, listened to the predictions of massive layoffs in the auto industry and began preparing for the anticipated rise in child abuse cases. His caseload last year was 1,114, up from 932 in 1973.

"The recession hit particularly hard here," Manzo said. "And we've seen a corresponding rise in our incidents. Our social agencies involved in marriage and family counseling have been busier than ever trying to keep marriages hanging together. But marriages are beginning to disintegrate along with increases in child cruelty."

Washington is one of the few areas of the nation that has been largely shielded from the recession, feeling only the tremors of the massive unemployment afflicting other areas but suffering nevertheless from the inflationary squeeze. And along with it, an increase in child abuse.

Constance Williamson of the D.C. Superior Court's Intra-Family and Neglect Branch said she saw a direct relationship between the District's increase in child abuse and the economic climate, and noted a trend toward more severe cases.

"In 1973, we had 486 neglect cases and 157 cases of abuse," Ms. Williamson said. "Last year, we had 476 cases of neglect but our abuse cases rose to 21. I can see no other social factors at work in society except tougher economic times. The children are simply becoming the victims of this recession.

"A lot of the cases we see are at the lower end of the social scale and the greater stress caused by the economic situation causes them to turn to increased use of alcohol and drugs. And when the money runs out more quickly and they can't pay for these things, they come home and frequently hit the kids.

It is a very serious problem. When I first came into this field I didn't believe there could be so many cases. Now I feel we see only the tip of the iceberg."

MARYLAND'S total of reported cases of abuse and neglect leapt from 931 in 1973 to 1,251 last year. Virginia recently released a detailed breakdown of its total for 1974, which was up 61 percent over the previous year.

The state health department logged 426 cases, up from 264 in 1973, with 11 cases resulting in death. In 248 or 58 percent of the cases, the child had been physically or sexually abused. Neglect accounted for 158 cases and 25 more were logged as having unknown causes.

Of the Virginia abuse cases, 43.5 percent involved beatings with a hand, an object or weapon, 11 percent of the youngsters were sexually abused, 6.5 percent were burned or scalded, 5.3 percent were pushed, thrown or dropped and 5.7 percent were hurt in some other manner.

Perhaps the best national overview of child abuse came from Mrs. Jolly K., the founder and president of

Parents Anonymous, a Los Angeles-based organization of parents who have abused their children, but who are making an attempt to break out of the cycle, much like members of Alcoholics Anonymous. Mrs. K. uses only the initial of her surname to preserve her own anonymity and as an example to parents who wish to join the organization.

Based on information from many of her chapters located to date in 33 states, Mrs. K. thinks the current child abuse situation is "explosive."

"There's been a noticeable increase that we feel is tied directly to the economic situation," she said. "Joblessness means there are more people staying at home all day because they are out of work.

"The cost of living goes up, inflation soars, the issue becomes more loaded, and stress mounts within the family. Maybe the man loses his job and he feels that he no longer fulfills his breadwinner role. It's a great blow to his ego. He becomes tense, the whole thing builds and builds and suddenly he strikes out — at the children. It's just like striking a match to an explosive situation."

Mrs. K. noted that in Los Angeles, the doubled murder rate of children had been accompanied by a sharp increase in child abuse and neglect cases, from 1,897 incidents investigated by the L.A. Police Department in 1973 to 2,183 last year.

Georgetown's Dr. Scribanu, in analyzing the trend, stressed that the current state of the economy was not, in itself, the cause of escalating child abuse.

"You can't say that people beat their children because they are out of work," the Romanian-born pediatrician said. "Hard economic times won't themselves produce child beaters. We know that there are specific components that come into play in child abuse cases and one of the main ones is stress.

"You can see then how the economic situation will have quite a bearing on this element. People who are out of work, who are on the brink of bankruptcy, are in crisis and if the potential is there, it is often the last drop in the bucket."

One of the frustrations in dealing with child abuse is trying to identify potential child beaters and prevent the incidents. While some progress has been made toward this end, it still isn't known what drives one mother to hold her infant's head underwater or burn its tender flesh with a cigarette when the baby cries, and another mother to respond with tenderness and soothing words.

What is clear in every case is that the offending parent needs psychiatric help. The nation's courts generally respond in this way when parents are brought up on neglect or abuse charges. Only in the most severe cases of child battering are parents sent to jail.

IF AN INCIDENT isn't too severe, say a simple neglect case, a judge at the preliminary hearing often will allow the child to be returned home under close supervision by a social worker.

But in more serious neglect cases, and invariably in those in which a youngster has been hurt in any way, judges immediately whisk the children out of the homes and into a foster care setting. Parents are often ordered to undergo intense psychiatric counseling, sometimes in tandem with group therapy involving other battering parents.

If good progress is made, a child victim will be eased slowly back into the home under close supervision, although there is no guarantee that the child won't be back in the emergency room a week later because psychiatrists and social workers aren't infallible.

That a child will be returned to the home and be beaten again is the kind of mistake that keeps those in the child abuse field awake nights. Experts say such recurrances happen with some regularity.

Another tragedy of the whole unfortunate syndrome is the fact that child abuse is a crime that breeds within itself. One of the few common threads running through many child abuse cases is that the parent who beats his or her child half to death was the victim of similar treatment as a child. And that may be the most tragic aspect of all to this extraordinarily common but little-understood problem.

Tomorrow's Portfolio section: Child molesting.

Taboo: Sexual Abuse of Children

Second of three articles

By Michael Satchell
Washington Star Staff Writer

It has been characterized as the unspeakable subject, the unthinkable thought, the ultimate taboo. Sexual abuse of children remains one of the least understood, most ignored and universally feared warps in the social fabric.

Authorities stress that the problem pervades society at every social, professional and economic level. Recent offenders brought before local courts include a pastor, a fire captain, a professional boxer and even a policeman. Wide publicity was given to the case of singer Peter Yarrow who admitted guilt in a sex case involving a 14-year-old girl in a District hotel. Star football flanker Lance Rentzel is still on probation after pleading guilty in Texas to a charge of exposing himself to a 10-year-old girl.

LAST YEAR, District police investigated 371 cases of sexual abuse, molesting or exposing involving girls and boys under the age of 15 and they are confident that hundreds more cases were never reported. Suburban police departments, while not maintaining the same detailed statistical breakdowns on juvenile sex crimes as the District, report that the problem appears to be equally as common in their jurisdictions and recently there has been no better illustration than the search for the two missing Lyon girls in Montgomery County.

Captain Gabriel LaMastra, who is heading the search for the 11 and 13 year old daughters of a WMAL radio announcer missing since March 25, has virtually ruled out the possibility they ran away and has voiced strong suspicions that they may be the victims of a sex crime.

FAIRFAX COUNTY'S chief social work supervisor Julia Barton confirmed that the problem of juvenile sexual abuse occurs in "even the best" of families. Said Mrs. Barton:"We have had enough referrals from the courts and police to indicate that the incidence of incest is much higher than we realize. I couldn't give you a detailed breakdown but it occurs a lot more often than most us would like to admit. And it's an occurrence that strikes across all economic levels."

Because society abhors the subject, it also tends to ignore it. But it won't go away and those who have been fighting this head-in-the-sand attitude — sex squad officers, social workers, psychiatrists, physicians and other professionals — insist that the problem is far more widespread than people believe, or want to believe. The number of reported cases, they say, is but the tip of the iceberg.

THE LEGACY of this ostrich logic is that society is poorly equipped to both deal with the overall problem, and try to prevent it.

Research into curing or preventing pedophiles from violating children is skimpy. Because of rigid legal requirements, the crime usually goes unpunished.

And the extent of the problem nationwide simply isn't known. The FBI compiles annual crime totals of such things as stolen cars, burglaries, rapes or bank robberies, but has no idea how many children were victims of sexual attacks.

"We are in the stone age in this area,"said Nan Huhn, an assistant D.C. corporation counsel in charge of the juvenile division."You would be amazed at how much of this goes on, and at the cases we see. People just have no idea."

ONE OF THE FEW comprehensive attempts to study the problem was completed in 1969 by the Children's Division of the Denver-based American Humane Association. Among the major findings of the three-year, 250-case study were the following:

- The problem is one of unknown national dimensions but findings "strongly point to the probability of an enormous national incidence many times larger than the reported incidence of physical abuse of children."
- It happens in families of every race and at every social and economic level. In the majority of cases,there were serious inter-family problems such as drugs or alcohol, child neglect or abuse, a deteriorating marriage or relationship, or some combination of these.
- Victims have been subjected to every conceivable type of sexual attack or activity.
- Offenders were predominantly males between 17 and 68 years of

age who tended to victimize children of their own race. Victims ranged from infants on up with the median age being 11 years and at the ratio of 10 females to one male.

- In three out of four cases, the offender was known to the child or to the child's family.

Sexual abuse of their children is the crime that parent's fear most, and it's a rare mother or father who doesn't worry about some "dirty old man" dressed in a shabby raincoat and skulking in the bushes when the youngsters head for the park. But the finding that 75 percent of the offenders are known to the child or family belies this fear to an extent.

"It's a popular misconception, but the vast majority of our cases involve the paramour — the live-in boyfriend — or the stepfather, occasionally an uncle, a male babysitter or the natural father," said the District's Nan Huhn whose sense of outrage at the offenders is matched only by her zeal in getting the children out of the home and trying to prosecute their abusers.

SHE DETESTS sexual abusers of children and has a special contempt for what she calls "these strange, passive women" who conceal assaults on their children for various reasons.

"My hangup is with the mothers who often know, or should know what is going on," she said. " But they don't report it. I had one case recently where the mother had to know. She had seen semen on the child's bed, blood on her underwear and she had seen her daughter and her paramour in bed together.

"Then she claims she didn't know what was going on. We find this in many cases and I still have trouble understanding these mothers who allow it to continue or who won't do anything about it. I mean, they actually know it's happening."

Mrs. Huhn's experience was echoed by Lt. Robert Caldwell, head of the D.C. Police Department's sex squad, a cop who sees perhaps the seamiest side of the lowlife and who forces himself to forget it at 4 p.m. sharp.

Said Caldwell: "We often find the mother is more concerned about what will happen to her boyfriend or her husband when we arrest him than what effect it will have on her child. Now how do you come to grips with that?"

Sexual activity involving children runs a broad gamut from the stranger who simply exposes himself in front of youngsters (relatively harmless, say the experts), to the individual who uses a child for sexual gratification and accompanies the assault with a beating, often if the child resists or threatens to tell.

"The children rarely resist," said Frank Mussell, an assistant corporation counsel who works in Mrs. Huhn's office."They are either too young to know what is happening, or too frightened if they do. Occasionally though, we do get a case where a child fights back although it's rare."

Mussell related with thinly disguised pleasure the case of one 13- year-old girl who took revenge on her mother's boyfriend after he had forced her into bed and was attempting to have intercourse. The girl managed to get away and returned with a butcher knife and stabbed the man in the genitals.

"After they stitched him up at the hospital, he was arrested and charged but was out on bail and back in the home the next day," Mussell recalled. "The mother was supposed to bring the child in to us but the kid ran away."

THOSE WHO DEAL with sex crime cases involving children see victims as young as 6 months, the infants incredibly subjected to attempted intercourse. Older victims, those approaching or reaching puberty, often have been used by their abusers for months or years without anyone finding out.

"The kid usually breaks when she decides she can't take it any longer," said Mrs. Huhn. "After two or three years of having to sleep with pappa, something snaps, and the kid often just runs away from home and the story comes out when she's picked up by the police.

"Sometimes, an older sister who has been used will finally blow the whistle when she sees a younger sister about to become a victim. And very often, the kids are simply too scared to tell their mother. They feel that momma won't believe them, so they keep quiet and take it."

A CIVIL HEARING is held within 24 hours of a reported offense and with only minimal proof of assault required, the judge usually orders the child into foster care. If the mother kicks her man out of the house, the child may be allowed home under close protective supervision.

Protecting the child by removing her — or him — from the home is legally easy. But criminal prosecutions are very difficult.

Frank Mussell explained: "First, the trauma of having to repeat what happened to police, to case workers, to prosecutors, to a grand jury and then in open court may be worse than the effect of the assault itself," he said. "Then there's the problem of corroboration.The child is usually assaulted when there are no witnesses around.

"A 5-year-old girl may have a perforated hymen, for example, but how do you prove that it was through intercourse unless you get the child to the hospital immediately after it happened? How does a youngster that young explain what happened?

"Often, older kid [redacted] terribly embarrassed and ashamed of what happened that they won't talk about it and especially in open court. And sometimes, say in an oral sodomy case, there's no physical evidence, no bruises, no perforated hymen, nothing to prove the child was assaulted., How do you prosecute then?

"The result is that the crime goes unpunished."

Aware of this problem, a D.C. Medical Society group studying sexual assaults on children recommended last year that closed circuit television cameras be allowed in court so the victim could present testimony without the ordeal of facing the accused in open court, as the 6th Amendment to the Constitution requires.

So far, D.C. Courts have not acted on the Medical Society's recommendation.

Tommorow: a medical and psychiatric view.

The Veil Cloaking Child Abuse

Victims Treated, Not the Causes

By Michael Satchell
Washington Star Staff Writer

(Last of three articles)

' Three years ago, a 42-year-old man charged with 14 counts of child molesting sat in the dock of a Denver, Colo. courtroom and sobbed to the judge: "Please help me. If you release me, I'll tell you I'll go right out and do it again because I can't help it."

He also testified that during his adult years he had molested somewhere between 400 and 500 little girls under the age of 12. The judge went ahead and agreed to the man's plea — not for mercy, but for permission to be castrated in the hopes of curbing his overwhelming compulsion.

THE DENVER castration case did not attract much public attention because it wasn't widely reported. But it created a furor among some psychiatrists and civil liberties groups who regarded the drastic and irreversible surgery as something akin to a barbaric leap backward into the Middle Ages.

To others it was one more example of the woeful lack of knowledge about what causes men, and occasionally women, to become sexual abusers or molesters of children, and of the dearth of methods to treat them. Most offenders end up behind bars which is about as effective a cure or deterrent as jailing drunks.

Reliable nationwide statistics aren't available. Many molestation incidents are not reported to the police because often, a child will not tell a parent. Parents who do learn that their child has been a victim often hush it up for fear of causing further emotional damage. In some homes, it's kept quiet because a relative or a live-in boyfriend may be involved.

Despite the absence of reliable statistics, most experts concerned with the problem feel that sexual abuse and molestation of children is far more deeply rooted and pervasive than most people realize, with anyone's child a potential victim and offenders coming from every walk of life or social and economic level.

PEDOPHILIA can be the compulsion of rich and poor, black and white, yet because of the distasteful nature of the problem, medical and psychiatric research into its prevention and cure have been minimal with most of the thrust aimed at treating the victims rather than preventing the crime in the first place.

"It's incredibly difficult to get research funds because everybody shies away from it," said Dr. John Money, a medical psychologist at Johns Hopkins

Hospital in Baltimore. "Everyone's afraid of burning their fingers and even the government is extremely reluctant to give money for this kind of research. The result is that treatment programs are negligible."

A spokesman for the U.S. Department of Health, Education and Welfare was unable to provide a list of federal grants for research into the problem because of statistical limitations, but a survey by The Washington Star indicates that only a handful of research programs are currently underway nationwide, one of them being conducted by Dr. Money, a noted specialist on sex hormones.

Money's subjects, all volunteer referrals and most of them men who either expose themselves to children or nonviolently molest them, are given weekly doses of an androgen-depleting hormone. The result is a sort of chemical castration, or in Money's view:"It gives the person a vacation from his sex drive."

The treatments are combined with intensive counseling sessions aimed at giving the offender a "psychic realignment", channelling his sex drive into more acceptable behavior. So far, results have been promising, Money says, with about half his subjects being able to settle down to "normal" sex lives.

Because of the recent controversy over the use of prisoner-patients in medical experiments, particularly at the Patuxent Institution in Maryland, Money is forbidden to recruit inmate offenders for his research, a fact that annoys him intensely.

"THESE FANATICAL crackpots have made such a fuss of the ability of prisoners to give informed consent to participate in these research programs that I cannot use anyone who has been arrested or is in jail,"Money complained. "With something as drastic as brain surgery, you can understand the concern for a prisoner's civil rights but the pendulum has swung too far with the result that progress into understanding this, and many other problems, is severely hampered."

Researchers in other states do not share Money's handicap. At the Connecticut State prison in Somers, doctors are experimenting with a controversial type of aversion therapy similar to the treatment that the violence-loving Alex was forced to undergo in the movie "Clockwork Orange."

Hypnosis and electric shock punishments are employed as tools to try and redirect the volunteer offender's sex drive. Simply stated, a homosexual child molester, for example, will be shown slides of nude young boys, along with slides of naked women in provocative poses. The boy pictures will be accompanied by a slight electric shock, the adult women pictures with encouragement to enjoy and remember them.

In Rahway, N.J., inmates at the state prison there go through intensive group therapy. About half of the offenders in the program were themselves victims of molesters and they are encouraged to relive their childhood sexual experiences in a sort of drastic emotional catharsis.

Doctors at California's Atascadero State Hospital, operating under the theory that most child molesters have led highly inadequate social and sexual lives, teach offenders how to talk to and relate to adults, even to the point of volunteer counselors from local gay organizations teaching homosexual offenders how to pick up adult partners.

And that, as they say, is about it as far as research elsewhere goes.

At St. Elizabeth's Hospital here, Dr Eugene Stammeyer is studying 270 offender case histories, trying to probe the psychology of child molesters. He wants to learn the differences between them and adult rapists, between the molester who simply exposes himself or fondles a child to the more violent offender who attempts rape or other sexual acts with children.

"I can say from clinicial observation that people who molest chidren tend to be older and they are basically a very passive group," Dr Stammeyer said. "Those that commit any real brutality tend to be younger although those that accompany the act with brutality is very limited.

"Child molesters appear to be much more deviant psychologically and behaviorally than do adult rapists. One of the outstanding characteristics is that they tend to be very timid socially, to be very shy and withdrawn.

"Fondlers and exhibitionists may lead otherwise perfectly normal lives. But those who become more assaultive, who attempt intercourse with a child, tend to be very impulsive people. For them, it often doesn't make any difference whether their partner is an adult or a child and alcohol is often a factor in these assaults. They get drunk, their impulse control is taxed and they act out."

JOHNS HOPKINS' Dr. Money agrees with Dr. Stammeyer and he feels that the simple exhibitionist or the nonviolent child molester really isn't the kind of monster that society fears him to be, although he will doubtless get a strong argument on that conclusion from many parents.

"Molesters and exhibitionists are really very ordinary human beings struggling with a compulsive problem," Money argued." Most of these people are very affectionate. They are kind to kids and there's no cruelty involved.

"The exhibitionists get into trouble because they take their pants off, and there is no evidence that it harms children to see a man's penis. I'm not saying that there should be child molesters in the world, everybody would be much better off if there weren't any. But society has produced these stigmatized people by over-reacting."

While this "over-reaction" is understandable in a society that venerates the young and is often overly protective of childen in many ways, those who deal with the victims of sexual abuse say the psychic harm that results can be extremely damaging depending on the type and severity of the offense.

Dr. Annette Ficker is the staff pediatrician to the D.C. Children's Hospital child abuse team, and she sees the victims of pedophilia when they generally are at their worst — scared, dazed, confused and often physically injured when they are brought into the emergency room. It is, she said simply, a "very bad experience" for all concerned.

"Molesting or sexual abuse can be a very traumatic experience both physically and psychologically," Dr. Ficker said. "Physically, it can be both damaging and very painful, for boys as well as girls. But the physical wounds usually heal. I believe the worst damage is emotional."

An infant too young to realize what is happening probably will not have lasting mental scars, Dr. Ficker and several other experts agree. But the older child faces a host of potential problems in trying to overcome the memory and heal the psychic wounds.

SOME CHILDREN sink into an abyss of depression. Some grow to fear and hate men and as they reach adulthood are unable to enjoy a satisfactory sexual relationship. For others the result is the opposite and the frigidity that gradually atrophies one victim's sexuality may become driven promiscuity in another.

The young victims often undergo behavioral changes. School grades may suffer. Relationships with other members of the family may change. Psychosomatic complaints sometimes result with the child being unable to sleep, or complaining constantly of headaches, abdominal pains or such problems.

"I think kids experience the same kind of stigma that a rape victim feels, but they are totally unable to handle it," said Jim Shannon, a Children's Hospital social worker who specializes in these cases. "And it's the exceptional family that can bring the kid out of this themselves. They need good psychiatric help to overcome the trauma."

Until the researchers come up with some sort of therapy or cure for those who molest or otherwise sexually abuse children, prevention will continue to be a strictly hit or miss proposition for it is the kind of crime that police can do little to prevent bearing in mind that studies show three out of four offenders are known to the child or the victim's family.

"You could put a thousand officers on each block and not prevent it," said Lt. Robert Caldwell head of the D.C. Police Department sex squad. "Maybe if society doesn't keep ignoring this problem, we may start to make some progress toward solving it."

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